**Text

Description automatically generated with medium confidence Voices for Palliative Care – Expression of Interest Form**

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| **Personal Details** |  | | |
| Full name: |  | | |
| Location / State: |  | | |
| Contact number: |  | | |
| Email address: |  | | |
| Occupation / area of study / other: |  | | |
| Gender: | ☐ Male  ☐ Non-binary/gender diverse | | ☐ Female  ☐ Prefer not to say |
| Age: |  | | |
| Ethnicity: |  | | |
| Do you identify as Aboriginal or Torres Strait Islander? | ☐ Yes  ☐ No | If yes, please specify:  ☐ Aboriginal  ☐ Torres Strait Islander  ☐ Aboriginal and Torres Strait Islander | |
| Please tick any that apply (*optional*): | ☐ Migrant or refugee background  ☐ Regionally based  ☐ Person with a Disability  ☐ LGBTIQ+  ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| **Your Palliative Care Experience** | Please indicate your experience by marking **X** onall that apply |
| Which applies to your experience? | ☐ I am a patient  ☐ I am currently a carer  ☐ I have been a carer  ☐ I am/have been both a patient and carer |
| Which type of disease(s) does your experience fall under? Tick any that apply | ☐ Cancer  ☐ Heart disease  ☐ Respiratory disease  ☐ Immune disorder  ☐ Renal disease  ☐ Dementia  ☐ Infectious disease  ☐ Rare and less common disease(s)  ☐ Neurological disease  ☐ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What is your experience with palliative care services? Tick any that apply | ☐ Inpatient palliative care (palliative care unit)  ☐ Outpatient palliative care consultation(s)  ☐ Community palliative care  ☐ None  ☐ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Share about your interest** | |  |
| Please share with us a short statement (max. 250 words) describing why you are interested in joining **Voices for Palliative Care,** describing any skills or experiences you wish to highlight: | | |
| Do you belong to an organisation or network of other consumers related to palliative care and/or serious illness? | ☐ Yes  ☐ No  \* If yes, please provide name of organisation / your role:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Have you undertaken training in consumer representation in health? | ☐ Yes  ☐ No  \* If yes, please provide details (*name of group(s) providing training, duration, dates*)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| If not, would you be willing to participate in a consumer training workshop? | ☐ Yes  ☐ No | |

**Contact us:** If you would like to discuss this Expression of Interest Form, receive this Form in a more accessible format, or have any questions about **Voices for Palliative Care**, please contact Mollie Wilson [mollie.wilson@svha.org.au](mailto:mollie.wilson@svha.org.au)