Children's MINNESOTA

FAMILIES AS PARTNERS

Today's Date: _____

1. **Your Name: _____**

2. **Home Street Address: _____ City: _____ State: ___ Zip: _____**

3. **Phone Number: Daytime: _____ Evening: _____**

4. **Email Address: _____**

5. Languages spoken in the home: _____

6. Occupation: _____

7. Name of child with health needs/experiences (if more than one child please add under question # 9):

   _____Child's DOB: _____Relation to you: _____

8. Child's Primary Diagnosis: _____

9. Other children? ☐ Yes (please enter names and dates of birth) ☐ No

   _____

10. Which campus does your family primarily use: _____
    Has your family used other Children's locations? (Check all that apply.) ☐ Mpls. ☐ St. Paul ☐ Minnetonka ☐ Roseville ☐ Maple Grove ☐ Woodwinds

    Has your family used a pediatric clinic aligned with Children's? (Check all that apply.)
    Metropolitan Pediatric Specialists: ☐ Edina ☐ Burnsville ☐ Shakopee
    Northeast Pediatric Clinic: ☐ Hugo
    PACE Clinic: ☐
    Partners in Pediatrics: ☐ Brooklyn Park ☐ St. Louis Park ☐ Maple Grove ☐ Plymouth ☐ Rogers
    Other: ☐ _____

11. Would you be able to make a commitment to join committees, family panels, etc. held on various dates and times?
    ☐ Yes ☐ No

    If yes, what is your availability? Please indicate the hours you are available:

Day:	Monday	Tuesday	Wednesday	Thursday	Friday	Weekends
Daytime:						
Evening:						

Comments on availability?

_____

_____

_____

_____

12. What services has your family used? (Check all that apply.) Check **Past Year** if you have used this service within the past year; **Ever** if you have ever used this service.

Past Year	Ever		Past Year	Ever	
☐	☐	Emergency Room (ED)	☐	☐	Hematology/Oncology
☐	☐	Special Care Nursery (SCN)	☐	☐	Home Care or Hospice
☐	☐	Neonatal ICU (NICU)	☐	☐	Immunology
☐	☐	Pediatric ICU (PICU)	☐	☐	Integrative Medicine
☐	☐	Day/Outpatient Surgery	☐	☐	Lab
☐	☐	Short Stay (SSU)	☐	☐	Mother Baby (Mpls.)
☐	☐	Infant Care Center (ICC)	☐	☐	Nephrology
☐	☐	Other Inpatient Unit(s): _____	☐	☐	Neurology
Specialty Services:			☐	☐	Neurosurgery
☐	☐	Adolescent Medicine	☐	☐	NICU follow up Clinic
☐	☐	Asthma/Allergy	☐	☐	Orthopedics
☐	☐	Audiology	☐	☐	Pain Team/Palliative Care
☐	☐	Autism	☐	☐	Pharmacy
☐	☐	Birth Center (St. Paul)	☐	☐	Psychiatry
☐	☐	Cardiology	☐	☐	Psychology
☐	☐	Cath Lab	☐	☐	Respiratory/Pulmonology
☐	☐	Cleft/Craniofacial Clinic	☐	☐	Radiology
☐	☐	Cystic Fibrosis Clinic	☐	☐	Sleep Lab/Clinic
☐	☐	Developmental Clinic	☐	☐	Special Diagnostics
☐	☐	Down Syndrome Clinic	☐	☐	Surgery
☐	☐	Ear, Nose, and Throat	☐	☐	Trauma
☐	☐	Eating Disorders	☐	☐	Urology
☐	☐	Endocrine/Diabetes	☐	☐	Other: _____
☐	☐	Epilepsy Clinic	Rehabilitation:		
☐	☐	Feeding Clinic	☐	☐	Animal Assisted Therapy
☐	☐	Gastroenterology/ GI	☐	☐	Occupational Therapy
☐	☐	General Pediatric Clinic	☐	☐	Physical Therapy
☐	☐	Genetics	☐	☐	Speech/Language Therapy

13. Have you used the following non-medical services? (Check all that apply.)

☐ Bereavement Services	☐ Ethics Consult	☐ MyChildren's
☐ Caring Bridge Web Site	☐ Family Resource Center	☐ Ronald McDonald House
☐ Chaplaincy	☐ Financial Counseling	☐ Sibling Play
☐ Child Life	☐ Geek Squad	☐ Social Work
☐ Children's Web Page	☐ Interpreter Services	☐ Other: _____

14. What do you feel you could bring to Families as Partners?

_____

_____

_____

_____

_____

_____

_____

I acknowledge that I have provided accurate information to the best of my ability and have been fully vaccinated against COVID-19.

_____ _____

Applicant Signature Date

Please send the completed application and a PDF of your Covid-19 vaccination card to:

Families as Partners
Mail Stop 70-503
Children's Minnesota
345 North Smith Avenue
St. Paul, MN 55102