## 2017 National Palliative Care Standards Review Consultation Round

expression of interest FORM

|  |  |
| --- | --- |
| Service/organisation name |  |
| **Main contact person** |  |
| **Email address** |  |
| **Phone number** |  |
| **Second contact person** |  |
| **Email address** |  |
| **Phone number** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **In which state or territory is your service/organisation located in?** | | | |
| ACT | NSW | NT | Qld |
| SA | Tas | Vic | WA |

|  |  |  |
| --- | --- | --- |
| **In which type of area is your service/organisation located?** | | |
| Metropolitan | Inner regional | Outer regional |
| Rural | Remote | |

|  |  |  |
| --- | --- | --- |
| **To which group/s does your service/organisation deliver care?** | | |
| Adult | Paediatric | Aged care |

|  |  |  |
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| **Is your service/organisation public or private?** | | |
| Public | Private |  |

|  |  |  |
| --- | --- | --- |
| **Which type of service/s does your service/organisation provide?** | | |
| Direct care  (eg. inpatient, hospice) | Ambulatory  (eg. outpatient, community) | Consultative  (inreach services) |