## 2017 National Palliative Care Standards Review Consultation Round

expression of interest FORM

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

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

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

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| **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 |  |

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