

## Patient Allies Consulting

### Workshop Request Form

*\*\*Please try to complete as much of this form as possible. Incomplete forms will slow down workshop scheduling. Thanks for your understanding.*

**Date of request:** \_\_\_\_\_

**Contact Person/Title:** \_\_\_\_\_

**Phone number:** \_\_\_\_\_ ext \_\_\_\_\_

**Email address:** \_\_\_\_\_

**Preferred contact method:** Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Either: \_\_\_\_\_

**Location of Workshop:**

\_\_\_\_\_  
**Date and Time Preferences:** (please list them in order of preference)

1.

2. \_\_\_\_\_

3.

**Desired length of workshop:**

\_\_\_\_\_ 45-60 minutes \_\_\_\_\_ 2 hours \_\_\_\_\_ Other (specify):  
\_\_\_\_\_

**Type of workshop desired: (check all that apply)**

Patient: \_\_\_\_\_ School: \_\_\_\_\_ Organization: \_\_\_\_\_

Corporate: \_\_\_\_\_ Community: \_\_\_\_\_ Other: (please describe below):  
\_\_\_\_\_

\_\_\_\_\_  
**Approximate audience number:** \_\_\_\_\_ **Age range:** \_\_\_\_\_

**Educational level and background of audience:** (check all the apply)

\_\_\_\_\_ No prior knowledge of the topic \_\_\_\_\_ Some knowledge of the topic \_\_\_\_\_ Expert

knowledge of topic \_\_\_\_\_ Audience has varying degrees of knowledge \_\_\_\_\_ Child level

materials needed \_\_\_\_\_ High School Educated \_\_\_\_\_ College Educated \_\_\_\_\_ Graduate

educated \_\_\_\_\_ Medical Knowledge- Allied health/nurse \_\_\_\_\_ Doctor level:

\_\_\_\_\_

**Topic(s) desired:** (select all that apply in order of preference)

*\*\*Please note...many workshops will have to be done in more than one session..first session is complimentary.*

\_\_\_\_\_ Disease Management \_\_\_\_\_ Coping \_\_\_\_\_ Work issues

\_\_\_\_\_ Benefits \_\_\_\_\_ Managing chronic illness employees on the job

\_\_\_\_\_ Talking to your drs \_\_\_\_\_ Getting a Second Opinion \_\_\_\_\_ How to

find medical resources and information \_\_\_\_\_ Finding free events or things to fill your time

\_\_\_\_\_ Being an empowered patient \_\_\_\_\_ Navigating the healthcare system

\_\_\_\_\_ Caregiving for a person with chronic or acute health issues \_\_\_\_\_

Developing a strong support system \_\_\_\_\_ Chronic Illness Awareness and Sensitivity

Training \_\_\_\_\_ Other topics you'd like (please describe in detail below):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Materials/ Equipment/Space Available:**

Conference room \_\_\_\_\_ Slide projector \_\_\_\_\_ Screen for Slide projector

\_\_\_\_\_ Computer \_\_\_\_\_ Podium \_\_\_\_\_ Microphone for Podium

\_\_\_\_\_ Portable Rooming Microphones \_\_\_\_\_ Other:

\_\_\_\_\_

**Budget:** \_\_\_\_\_

**Special financial needs:** (describe in detail):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Agreed upon rate quote** (to be filled in by patient allies rep): \_\_\_\_\_

**Other Comments Or Info You'd Like Us to Know to Enhance the success of your workshop:**

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**Directions to your Location:**

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*Thank you for taking the time to complete this form. Once completed, please email, fax to us or mail to us at:*

**Nancy Jay  
c/o Patient Allies  
5126 N Granite Reef Rd  
Scottsdale, AZ 85250**

*\*Please allow about 1-2 weeks for us to get back to you after receiving your completed form*