Blood Synergy

Blood Synergy Advisory Committee
Consumer and Community Representative Contact Form

Please return the completed form to: sphpm.bloodsynergy@monash.edu

Personal Details	
Full name	
Postal address	
Contact number	
Email address	

Your Transfusion Experience	Please indicate your experience by marking X on all that apply
Which applies to your experience? (select all that apply)	☐ I am a transfusion recipient ☐ I was previously a transfusion recipient ☐ I am/was a donor ☐ I am/was a carer/guardian of a transfusion recipient
Which category describes the reason for transfusion(s)? (select all that apply)	☐ Blood Disease (incl. Blood Cancers) ☐ Surgery ☐ Trauma or injury ☐ Other ☐ N/A (Donor only)
Briefly describe your experience with blood transfusion(s) or donation? *If comfortable and appropriate, please list the type of disease, surgery, trauma or injury*	

Consumer Involvement	
What qualities, perspectives and life skills would you contribute as a consumer and community representative?	
Are you currently involved with a consumer organisation and/or have you acted as a consumer representative on a committee or board previously? *If yes, please name the organisation, and describe your role.*	☐ Yes ☐ No
Do you work for any health or research institutions or foundations? *If Yes, where?*	☐ Yes ☐ No