Communication Action Plan

|  |  |  |  |
| --- | --- | --- | --- |
| Please alert all staff and include in Medical Record | | | |
| NAME OF PATIENT: | DATE OF BIRTH: | | MRN:  (Office Use) |
| Which Describes You? | | | |
| ☐ Hard of Hearing           ☐ Deaf           ☐ DeafBlind           ☐ Low Vision | | | |
| Which Device(s) Do You Use? | | | |
| Hearing Aid(s)             ☐ Right     ☐ Left  Cochlear Implant(s)     ☐ Right     ☐ Left  Other Implant(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| What Do You Need Hospital/Office to Provide? | | | |
| ☐ Pocket Talker  ☐ Captioned Phone (Hospital only)  ☐ TTY (Hospital Only)  ☐ Video Phone  ☐ Other Alerts or Assistive Device(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| What Services Do You Need? | | | |
| ☐ Communication in writing  ☐ Communication Access Realtime Translation (CART)  ☐ Sign Language Interpreter  ☐ Tactile Interpreter  ☐ Video Remote Interpreter (VRI)  ☐ Other:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Waiting Room Practice | | | |
| When it is time for me to be seen by my health care provider: | | ☐ Provide a vibrating pager, if available  ☐ Come speak to me face-to-face  ☐ Write me a note and hand it to me | |
| For scheduling/follow up communication, please contact me by: | | | |
| ☐ Cell Phone      ☐ Home Phone       ☐ Work Phone     ☐ Video Phone      ☐Relay  ☐ Patient Portal       ☐ Email                         ☐ Text                        ☐ U.S. Mail | | | |
| Notes: | | | |
|  | | | |