Communication Action Plan

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| 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:    |
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