Check appropriate Facility: Patient Label
☐CLMC ☐CLHRC ☐CUMC ☐FLMC ☐FSRMC
☐FSSNH ☐LCMC ☐MMC ☐MHHS ☐PMC ☐RMC ☐TCU

Communication Assessment Form /Right to Interpreter
(Deaf/Hard of Hearing Patient or Companion)

Name: _____

Time/Date: _____Reason for Admission/Visit: _____

REVIEW AND COMPLETE THE BELOW WITH THE INDIVIDUAL USING VIDEO REMOTE INTERPRETIVE SERVICES (STRATUS)

To ensure effective communication with patients and their companions who are deaf or hard of hearing, this facility provides appropriate auxiliary aids and services free of charge, such as video remote interpreting services, sign language and oral interpreters, note takers, written materials, TTYs or relay services, and televisions with caption capability. Please ask the house supervisor at any time for assistance. You can contact the house supervisor by calling the operator at the hospital's main number at any time (voice or TTY), and the operator will page the house supervisor.

The information you provide will assist staff and/or medical providers in communicating effectively with you, whether you are a patient or companion. All communication aids and services are provided to you at the facility's expense and at no cost to you. Aids and services to ensure effective communication are available on request throughout a patient's time at the facility.

This facility has a grievance resolution mechanism. If you have a complaint about a communication aid or service, please contact the house supervisor by dialing the hospital operator (voice or TTY) so that we can promptly resolve your concern. If we cannot resolve your concern right away, you have a right to receive a written response.

1. Nature of Impairment: ☐ Deaf ☐ Hard of Hearing
☐ Speech Impairment ☐ Other:_____

2. Relationship to patient:
☐ I am the patient ☐ Family Member
☐ Designated Patient Representative ☐ Power of Attorney
☐ Companion
☐ Other: _____

If you are **NOT** the Patient, what is the Patient's name:_____

3. Would you like to request the use of a qualified sign language interpreter?

☐ Yes, I would like to request the use of a qualified interpreter using Stratus, a video remote interpreting service.

☐ Yes, I would like to request the use of an on-site qualified interpreter.

☐ No, I do not want to use a qualified sign language interpreter. Instead I would prefer: _____
Please sign Waiver of Interpretive Services below.

4. Please identify what services you will need in the patient's room if patient is admitted: ☐NA

☐Telephone with volume adjustment
☐Flasher for incoming calls
☐Closed caption for television set
☐Assistive Listening devices
☐Paper and Pen for Writing
☐Other:_____

5. I understand that for any communication aid requested, if the communication aid would adversely delay the patient's medical treatment, other aids or services will be used in accordance with the medical provider's best clinical judgment.

6. If my preferences change during my time at the facility, I agree to notify my nurse or the house supervisor.

_____ _____
Signature of Individual Who Is Deaf or Hard of Hearing (or legal representative)
Date/Time

CONTINUE BELOW ONLY IF YOU <u>DO NOT WANT</u> THE FACILITY TO PROVIDE A SIGN LANGUAGE INTERPRETER:

<u>WAIVER OF INTERPRETER SERVICES</u>

I understand I have a right to a free qualified sign language interpreter to communicate with this facility's staff and independent contractor doctors effectively. However, I DO NOT WANT A FREE QUALIFIED, SIGN LANGUAGE INTERPRETER to be provided to me by the facility. Instead, I prefer to use the methods of communication I selected on the Communication Assessment Form.

I understand that if one of my preferences is to have my family member and/or friend serve as an interpreter for me, I consent to disclosure of my health information to such individual and I agree the family member/friend can correctly and accurately communicate the information being conveyed by the patient's healthcare providers to me.

If my preferences change during my time at the facility, I agree to notify a nurse or the house supervisor immediately. I understand the house supervisor can be reached by calling the operator at the hospital's main number at any time (voice or TTY), and the operator will page the house supervisor.

_____ _____
Signature of Individual Who Is Deaf or Hard of Hearing (or legal representative)
Date/Time

GIVE COPY TO INDIVIDUAL, SCAN TO CHART, AND LOG REQUEST