Place Patient Sticker Here or
write patient name and DOB

Communication Assessment Form /Right to Interpreter
(Deaf/Hard of Hearing, Limited English Proficiency Patient or Companion)
CH80850050 (05/26)

Name: _____

Date of Birth: ____/____/_____

Date/Time: _____ Reason for Visit: _____

Note to Staff – Please provide Interpreter services to assist with completing form as necessary.

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/office's expense and at no cost to you (including but not limited to 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 office manager or the house supervisor at any time for assistance. Calling the main number of the office/facility and asking to speak with the respective party will connect you with the correct person.

If you have a concern or grievance about a communication aid or service, please contact the Covenant Health Integrity-Compliance Office at 1-888-731-3115 or IntegrityCompliance2@covhlth.com.

1. Person needing assistance:
   - ☐ Patient
   - ☐ Family Member
   - ☐ Companion
   - ☐ Other: _____
   - ☐ Power of Attorney
   - ☐ Designated Patient Representative

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

2. Nature of Barrier:
   - ☐ Deaf
   - ☐ Preferred language other than English (list language) _____
   - ☐ Hard of Hearing
   - ☐ Speech Impairment_____
   - ☐ Other: _____

3. Would you like to request the use of a qualified interpreter?
   - ☐ Yes, I would like to request the use of a qualified interpreter
     - ☐ Video Device
     - ☐ In Person
   - ☐ No, I do not want to use a qualified interpreter
     Instead, I would prefer: _____

When declining interpreter, please sign the Waiver of Interpretive Services below as well.

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

5. If my preferences change or I have a concern, I agree to notify the office manager or house supervisor.

_____
Signature of Individual/Legal Representative **Date/Time**

_____
Relationship To Patient

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

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

CONTINUE BELOW ONLY IF YOU DO NOT WANT US TO PROVIDE AN INTERPRETER:

WAIVER OF INTERPRETER SERVICES

I understand I have a right to have a free qualified interpreter to communicate with staff and independent contractor doctors effectively. However, I DO NOT WANT A FREE QUALIFIED INTERPRETER to be provided to me. 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 or I have a concern, I agree to notify the office manager or house supervisor.

_____

Signature of Individual/Legal Representative **Date/Time**

_____

Relationship To Patient

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