

Communication Access Plan (CAP)

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:

- Patient Portal Email Text U.S. Mail
 Cell Phone Home Phone Work Phone Video Phone Relay

Notes:

