



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?			
<input type="checkbox"/> Hard-of-Hearing <input type="checkbox"/> Deaf <input type="checkbox"/> Deaf-Blind <input type="checkbox"/> Visually Impaired			
Which Device(s) Do You Use?			
Hearing Aid(s) <input type="checkbox"/> Right <input type="checkbox"/> Left Cochlear Implant(s) <input type="checkbox"/> Right <input type="checkbox"/> Left Other Implant(s): _____			
What Do You Need Hospital/Office to Provide?			
<input type="checkbox"/> Pocket Talker <input type="checkbox"/> Captioned Phone (Hospital only) <input type="checkbox"/> TTY (Hospital Only) <input type="checkbox"/> Other Alerts or Assistive Device(s): _____			
What Services Do You Need?			
<input type="checkbox"/> Communication in writing <input type="checkbox"/> Communication Access Real-time Translation (CART) <input type="checkbox"/> Sign Language Interpreter <input type="checkbox"/> Tactile Interpreter <input type="checkbox"/> Video Remote Interpreter (VRI) <input type="checkbox"/> Other: _____			
Waiting Room Practice			
When it is time for me to be seen by my healthcare provider:	<input type="checkbox"/> Provide a vibrating pager, if available <input type="checkbox"/> Come speak to me face-to-face <input type="checkbox"/> Write me a note and hand it to me		
For scheduling/follow up communication, please contact me by:			
<input type="checkbox"/> Patient Portal	<input type="checkbox"/> Email	<input type="checkbox"/> Text	<input type="checkbox"/> U.S Mail
<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Home Phone	<input type="checkbox"/> Work Phone	<input type="checkbox"/> Video Phone <input type="checkbox"/> Relay
Notes:			