

# 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     Deaf-blind     Visually Impaired

### 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)  
 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: