Communication Access Plan (CAP)

Please alert all staff and include in Medical Record

NAME OF PATIENT:	DATE OF BIRTH: mm/dd/yyyy	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)
☐ Alerts
☐ Other Assistive Device(s) _____

What Services Do You Need? (Check all that apply)

☐ Communication in writing
☐ Communication Access Real-time Translation (CART)
☐ Sign Language Interpreter
☐ Tactile Interpreter
☐ Other _____

Waiting Room Practice

When it is time for me to be seen by my healthcare 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: