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: