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: