Communication Access Plan (CAP)

Please alert all staff and include in Medical Record

NAME OF PATIENT:	DATE OF BIRTH:	MRN: (Office Use)
Susan Smith	01/05/1980	

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:

For check-up appts - speechreading with written notes will be fine.
For in-depth or critical discussions, I will need CART.
For MRI's - a second staff person will be needed to provide tactile clues.

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