



Exhibit A

Deaf or Hard of Hearing Communication Request Form

We ask this information so that we can communicate effectively with patients and/or companions who are deaf or hard of hearing. All communication aids and services are provided FREE OF CHARGE. Each person requesting communication aids should complete a separate form. If you need further assistance, please contact _____.

Patient's Name

Medical Record #

Name of Person with Disability (if different than patient)



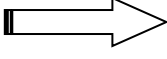
Nature of Disability:

- Deaf Hard of Hearing Speech Impairment Other: _____

Relationship to Patient:

- Self Family member Friend Other: _____

Please select the communication aid(s) you would like to assist you in communicating with Hospital staff. Your requests will be carefully addressed by Hospital staff.

<input type="checkbox"/> On-site Interpreter 		<input type="radio"/> American Sign Language (ASL)	<input type="radio"/> Signed English	<input type="radio"/> Oral interpreter	<input type="radio"/> Cued Speech
<input type="checkbox"/> Video Remote Interpreter (VRI)		<input type="radio"/> American Sign Language (ASL)	<input type="radio"/> Signed English	<input type="radio"/> Oral interpreter	<input type="radio"/> Cued Speech
<input type="checkbox"/> Videophone (VP)	<input type="checkbox"/> TTY/TDD (text telephone)	<input type="checkbox"/> Caption telephone	<input type="checkbox"/> Telephone compatible with hearing aid	<input type="checkbox"/> Telephone handset amplifier	
<input type="checkbox"/> Flasher for incoming calls (in patient's room)		<input type="checkbox"/> Assistive listening device (sound amplifier)			
<input type="checkbox"/> Other. Explain:					



- No. I do not use sign language and/or do not use interpreters.
- No. I prefer to have only family members/friends help with communication.

Name of family member/friend: _____

- No. Please state other reason: _____

If you requested both an interpreter on-site and a video remote interpreter above, do you have a preference between the two?

- Yes, I prefer an interpreter on-site
- Yes, I prefer video remote interpreter
- No, I do not have a preference between the two

If you have any questions, please call _____ (voice/VRS), _____ (TTY).

Completed by: _____
(Please print name)

Signature: _____

Date: _____ **Time:** _____

**** If at any point during your Hospital visit, you wish to change any of the answers to the questions on this form, please notify _____.**

For Official Use Only

- Anticipated period of time the patient will be in the hospital (if known): _____
- (dx date): _____
- The nature of the patient's condition, including its seriousness and stability: _____
- Likelihood of needing to communicate with the Patient or Companion at unforeseen times: _____
- In this unit, the most common hours that Hospital Personnel will need to communicate with patients or companions (list out in two hour time frames): _____
- Interpreter services are available 24 hours free of charge.
- Other assistive devices which may be available: _____