Inova™

1HEAR

Inova Staff:
1. **If accommodations are requested, page interpreter services at 98824 within 15 minutes of completing this form.**
2. **A new form should be used at every visit and any time a change in accommodations is requested.**

Name of Person Requesting/Declining Accommodations: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Family Member ☐ Friend ☐ Other _____

Do you and/or your companions have any special needs that require accommodations? ☐ **YES (complete boxes A and B)** ☐ **NO (complete box B)**

A. If you require special accommodations, please check as appropriate:

Deaf and Hard of Hearing:
☐ Sign language interpreter ☐ Notepad and pen ☐ Speak loudly
☐ Sound amplifier (ex. PockeTalker® or disposable Posey®)
☐ Uses hearing aid(s): ☐ Left ☐ Right ☐ Bilateral
☐ Amplified phone with flasher (if admitted)
☐ Video Remote Interpreter (VRI) (where available)
☐ Other: _____

Vision:
☐ Magnifying sheet ☐ Request an escort
☐ Braille phone ☐ Documents read out loud
☐ Other: _____

Mobility:
☐ Uses service animal ☐ Walking escort
☐ Wheelchair escort ☐ Extra-wide wheelchair escort
☐ Accessible exam table ☐ Accessible weight scale
☐ Other: _____

Speech:
☐ Point-to-Speak cards ☐ Point-to-Speak alphabet ☐ Notepad and pen
☐ Other: _____

Other or Special Instructions: _____

B. All Patients, Representatives and Companions, please read and sign:

By my signature below I hereby certify that: (1) I have been given an opportunity to communicate whether I and/or my companions have any special needs; (2) I have had the opportunity to select appropriate accommodations; (3) I have reviewed the above selections; (4) those selections are true, accurate and complete; (5) those selections reflect my and/or my companions' choices; and (6) I have received or can request a copy of the process for filing a complaint if I am unsatisfied with my own and/or my companions' accommodations. I understand that if my and/or my companions' needs change during my visit, I can request service changes from my caregiver free of charge.

☐ Patient's medical condition does not allow completion at this time.

Patient/Representative/Companion (signature)	**Patient/Representative/Companion** (print name)	Date	Time

Relationship to Patient: ☐ Self ☐ Parent ☐ Family Member ☐ Friend ☐ Other: _____

Staff Witness (signature)	**Staff Witness** (print name)	Date	Time	Contact #	Department

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID# (if applicable) _____
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver Signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova

Americans with Disabilities Act (ADA)/ Special Needs Assessment

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH
☐ IMG: _____ ☐ Other: _____

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