1HEAR

Inova Staff: At the first opportunity, provide this Special Needs Form to ALL patients and companions. Use completed form to initiate appropriate action and place form in patient's chart.

Patient or companions: It is important to us to communicate thoroughly with all of our patients and companions. To ensure that we provide effective communication during your stay, please complete the information below.

If you or anyone accompanying you have a special communication need, please indicate below:

In what language would you prefer to communicate with your providers?	☐ English	☐ Spanish	☐ Other (Specify) _____
Are you hard of hearing? Are you deaf?	☐ No ☐ No	☐ Yes ☐ Yes	If your response is "No" to both questions, then sign the form below. If your response is "Yes" to one or both of the questions, then sign the form below AND complete the information on the **Deaf or Hard of Hearing Communication Request Form.**

☐ Patient's condition does not allow and/or the companion is not available to complete the Special Needs Form.

Spoken language interpreters are available on site or by phone. If you prefer to communicate in a non English language, trained interpreters will be provided to you.

If your communication needs or those of your companion change during your stay/visit, or you need further assistance, please let your caregiver know and we will make accommodations to assist you.

_____ _____
Signature of Patient/Patient Representative/Companion Date

Print: _____

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

_____ _____
Signature of Employee Witness Date

Print: _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name _____

DOB: _____ MR# _____

INOVA HEALTH SYSTEM

SPECIAL NEEDS FORM

CAT # 87498/R102411 • PKGS OF 100