Faculty Group Practice

DEAF AND HARD-OF-HEARING PATIENT QUESTIONNAIRE

This document will help us understand the best way to communicate with you and to provide you with services you may need.

Patient Name: ______________________________ MRN: _____________

I am: Deaf ______ Hard of Hearing _____

I communicate in sign language ______ Yes _____ No

*I need a sign language interpreter ______ Yes _____ No

I can voice for myself ______ Yes _____ No

I am a good lip/speech reader ______ Yes _____ No

*I need an oral interpreter ______ Yes _____ No

I am comfortable communicating by writing ______ Yes _____ No

*If you would like an interpreter, one will be provided for you and the doctor free of charge.

If you need to contact me:

Please text me at ____________________________________

Please call me through a relay service _________________

Please fax me at __________

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