INOVA™

1ADA

Inova Staff: At the first opportunity, please complete this form with the patient or companion and have it scanned into the patient's electronic medical record. **Complete one form per person requesting accommodation.**

Patient or Companion: If you or any companion assisting in your care has a special need, please indicate below:

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

	Patient	Companion/Legal Guardian
Are you deaf or do you have serious difficulty hearing?	☐ Yes ☐ No	☐ Yes ☐ No
Are you blind or do you have serious difficulty seeing, even when wearing glasses?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have serious difficulty walking or climbing stairs? (5 years old or older)	☐ Yes ☐ No	☐ Yes ☐ No
Do you have any other special needs or disability that require services or accommodations during your visit today?	☐ Yes ☐ No	☐ Yes ☐ No
If you have indicated a need above, do you or your companion need services or accommodations related to your identified need(s)?	☐ Yes ☐ No	☐ Yes ☐ No

Please describe type of accommodation requested:

_____

_____

Do you have any special instructions for care providers? If so, please describe below:

_____

_____

Staff Notes regarding accommodations given: (**Inova Staff:** Please document in detail accommodation(s) requested and services given.)

_____

_____

By my signature below, I hereby certify that: (i) I have been given the opportunity to communicate whether I and/or my companion has a disability or special need requiring accommodation; (ii) I have had the opportunity to communicate my needs to staff as reflected above and that the above selections are true, accurate and complete; (iii) I understand that Inova Health System will use its best efforts to accommodate my requests and that any accommodations provided will be given free of charge; (iv) I have been offered/given a copy of the Patient Rights brochure which contains information for filing a complaint if I am unsatisfied with my requested accommodations during my visit today.

_____ _____

Signature of Patient/Patient Representative/Companion Date Time

Print: _____

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

_____ _____

Signature of Employee Witness Date Time

Print: _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name _____

DOB: _____ MR# _____

Inova Ambulatory Services

Americans with Disabilities Act (ADA)/ Special Needs Assessment

CAT # 20328DT-1P / R052714 • PKGS OF 100