



**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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