Communication Action Plan

Please alert all staff and include in Medical Record	
NAME OF PATIENT:	DATE OF BIRTH:

Which Describes You?

❑ Hard of Hearing ❑ Deaf ❑ DeafBlind ❑ Low Vision

Which Device(s) Do You Use?

Hearing Aid(s) ❑ Right ❑ Left

Cochlear Implant(s) ❑ Right ❑ Left

Other Implant(s):_____

_____

What Else Could Help You?

❑ Portable amplifier

❑ Sign Language Interpreter

❑ Captioned Telephone

❑ Communication in Writing

❑ Other Alerts or Assistive Device(s):_____

_____

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