INTAKE FORM:
SELECTION FORM FOR AUXILIARY AIDS AND SERVICES

To provide the best care to you during your visits at The Women's Group of Gwinnett, we ask that you complete the information requested below. We ask for this information so that we can effectively communicate with patients and family members/friends who are deaf or hard of hearing.

Are you or your family member or friend deaf or hard of hearing? **If no, sign below and return to a WGG staff member.**

NO - ______________________________ ______________________________
Signature Date

YES – Complete the information below.

______________________________ ______________________________
Name of Person with Disability Patient's Name

Relationship to Patient (circle all that apply):

Self Family member

Friend Other:____________________

I or my companion will need the service(s) circled below to enable effective communications while at The Women's Group of Gwinnett. All interpreter services are provided FREE OF CHARGE.

Interpreter on-site (Circle the type of interpreter needed)

American Sign Language (ASL)

Signed English

Oral

Paper and pen for writing notes

TTYs for telephone communication

Other: Explain:__________________________

Nothing requested at this time.

PRACTICE PERSONNEL WILL ARRANGE SERVICES OF INTERPRETERS

In order to ensure that we meet your healthcare needs, it may be necessary to start treatment before the arrival of an on-site interpreter. If that happens, do you want someone else to help with communication? If so, who ______________________________. We ask for your patience if it is necessary to use another form of communication in the event that emergency treatment is required.

If your needs change, please let your doctor or any employee of the Women's Group of Gwinnett know and we will make accommodations to assist you. If you need further assistance, please ask your doctor or other personnel.

______________________________ ______________________________
Patient Signature WGG Employee

______________________________ ______________________________
Date Date

PLACE IN PATIENT'S CHART