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/friend deaf or hard of hearing? **If no, sign below and return to a Women's Group of Gwinnett staff member.**

NO - _____ _____
Signature Date

YES – Complete the information below.

_____ _____
Name of Person with Disability Patient's Name

Relationship to Patient:

- ☐ Self
- ☐ Friend
- ☐ Family Member
- ☐ Other: _____

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

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

- ☐ American Sign Language (ASL)
- ☐ Signed English
- ☐ Oral
- ☐ Paper and pen for writing notes
- ☐ TTYs for telephone communication
- ☐ Other: _____
- ☐ 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