INOVA™

3ADA

Inova Staff: A list of disability and special need supports and instructions can be found on the back of this form. 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. Resource suggestions on the back.)

_____

_____

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 Health System

Americans with Disabilities Act (ADA)/ Special Needs Assessment

CAT # 20328DT/R052214 • PKGS OF 100

Inova Staff: Please discuss available services, aids or accommodations with the patient and/or companion. Complete one form for each person requesting accommodation. Note that not all items are available at each location. For a complete list of equipment available at your facility, check InovaNet.

Vision Services/Aids

	Date & Time Requested	Date & Time Provided
☐ Documents in large print		
☐ Documents read aloud		
☐ Screen magnifier		
☐ Magnifying sheet		
☐ Request escort		
☐ Special lighting		
☐ Braille phone		
☐ Modified call bell		
☐ Other (comment) ☐ _____ _____ _____		

Mobility Services/Aids

	Date & Time Requested	Date & Time Provided
☐ Walking escort		
☐ Wheelchair escort		
☐ Extra-wide wheelchair escort		
☐ Transfer assistance		
☐ Assistance positioning		
☐ Accessible exam table		
☐ Accessible weight scale		
☐ Modified call bell		
☐ Walker in room		
☐ Other (comment) ☐ _____ _____ _____		

Hearing Services/Aids

	Date & Time Requested	Date & Time Provided
☐ Assistive listening device (Pocketalker)		
☐ Disposable amplifier		
☐ Interpreter services		
☐ Point to speak cards		
☐ Notepad		
☐ TTY (If admitted)		
☐ Closed caption TV decoder (If admitted)		
☐ Amplified phone with flasher (If admitted)		
☐ Other (comment required) _____ _____ _____		

Other Special Needs

	Date & Time Requested	Date & Time Provided
☐ Cognitive impairment		
☐ Requires additional time		
☐ Sound sensitivity		
☐ Speech impairment		
☐ Uses point to speak cards		
☐ Uses service animal		
☐ Other (comment required) _____ _____ _____		

Special Instructions

☐ Uses hearing aids	☐ Uses notepad
☐ Speak loudly	☐ Knock before entering
☐ Speak slowly	☐ Announce your presence
☐ Make eye contact	☐ Read white board
☐ Reads lips	☐ Orient to changed surroundings
☐ Speak in right ear	☐ Uses service animal
☐ Speak in left ear	☐ Uses walker
☐ Uses point to speak cards	☐ Uses cane
☐ Wait for interpreter before communicating	☐ Other (comment required) _____ _____ _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name _____

DOB: _____ MR#_____

Inova Health System

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