Faculty Group Practice
DEAF AND HARD-OF-HEARING PATIENT QUESTIONNAIRE

This document will help us understand the best way to communicate with you and to provide you with services you may need.

Patient Name: _____ MRN: _____

I am: Deaf_____Hard of Hearing _____

I communicate in sign language _____ Yes _____ No

*I need a sign language interpreter _____ Yes _____ No

I can voice for myself _____ Yes _____ No

I am a good lip/speech reader _____ Yes _____ No

*I need an oral interpreter _____ Yes _____ No

I am comfortable communicating by writing _____Yes _____No

*If you would like an interpreter, one will be provided for you and the doctor free of charge.

If you need to contact me:

Please text me at _____

Please call me through a relay service _____

Please fax me at _____