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<br>❑ No | ❑ Yes<br>❑ No |
| Are you blind or do you have serious difficulty seeing, even when wearing glasses? | ❑ Yes<br>❑ No | ❑ Yes<br>❑ No |
| Do you have serious difficulty walking or climbing stairs? (5years or older) | ❑ Yes<br>❑ No | ❑ Yes<br>❑ No |
| Do you have any other special needs or disability that requires services or accommodations during your visit today? | ❑ Yes<br>❑ No | ❑ Yes<br>❑ No |
| If you have indicated a need above, do you or your companion need services or accommodations related to your identified need(s)? | ❑ Yes<br>❑ No | ❑ Yes<br>❑ 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:

_____

_____

By my signature below, I hereby certify that: (i) I have been giving 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

Print: _____

Relationship to Patient: ❑ Self ❑ Parent ❑ Family Member ❑ Friend ❑ Other _____

_____ _____

Signature of Employee Witness Date

Print: _____