General Accommodations Form

Name: _____

DOB: _____

MRN: _____

Which of the following conditions describe you (mark all that apply)?

- ☐ None
- ☐ Autism/Neurodivergence
- ☐ ADHD
- ☐ Blind
- ☐ Low Vision
- ☐ Trauma/PTSD/Anxiety Disorder
- ☐ Dementia
- ☐ Deaf
- ☐ Hard of Hearing
- ☐ Intellectual/Developmental Disability
- ☐ Physical/Mobility Difficulties
- ☐ Speech/Language Disorder
- ☐ Other: _____
- ☐ Prefer not to disclose

Please check any accommodations below that will improve your care.

MOBILITY

- ☐ Navigation Assistance
- ☐ Wheelchair
- ☐ Accessible Patient Room
- ☐ Bedside Commode
- ☐ Assistance with ADLS (specify)
  - ☐ Toileting
  - ☐ Dressing
  - ☐ Eating
  - ☐ Bathing
  - ☐ Brushing Teeth
  - ☐ Transferring

VISUAL SUPPORTS

- ☐ Visual Schedules/Agendas or Checklists for Encounter
  - ☐ Written
  - ☐ Pictures
  - ☐ Objects
- ☐ Pictures or diagrams to explain procedures
- ☐ Demonstrate exam or equipment before use

COMMUNICATION

- ☐ ASL Interpreter
- ☐ Oral Interpreter
- ☐ Cued Speech Interpreter
- ☐ CART (Communication Access Real Time Translation)
- ☐ Clear Mask
- ☐ Qualified Reader
- ☐ Qualified Writer
- ☐ Tactile Interpreter
- ☐ Materials Provided in Braille
- ☐ Magnification Device
- ☐ Large Print Written Materials
- ☐ AAC Device
- ☐ Avoid Open-Ended Questions
- ☐ Simple Language/Limit Extra Words
- ☐ Allow Extra Time for Processing
- ☐ Repetition or Clarification

Preferred Method of Communication

- ☐ Verbal
- ☐ Written
- ☐ Pictures
- ☐ Models

SEONSORY/EMOTIONAL

- ☐ Dim lights/limit bright lights
- ☐ Quiet Area
- ☐ Limit loud noises
- ☐ Limit strong smells
- ☐ Limit people in room
- ☐ Breaks during appointment
- ☐ Bring/keep comfort item throughout encounter
- ☐ Support person present through whole encounter

SCHEDULING/ ADMINISTRATION

- ☐ Phone Calls
- ☐ My Chart Only
- ☐ Longer Visit Time
- ☐ First appointment of the day

FOLLOW UP/ PATIENT INSTRUCTIONS

- ☐ Highlight or Bold Important Elements
- ☐ Provide Detailed Instructions