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Corporate member of the ATA
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OHIOHEALTH

INTERPRETING SERVICES VERIFICATION FORM

Interpreter's Name: _____

Agency/Contingent: _____

Date of Request: _____ faxed called in

Staff Making Referral: _____ Telephone: _____

Location: _____

RMH-GMC-AMB-GRADY-HOME (please circle one) Please be as specific as possible

Site Contact Person: _____ Phone: _____

Appt. Date: _____ Appt. Time: _____ am/pm

Procedure: _____

Patient's Information:

Last Name: _____ First Name: _____

Date of Birth: _____ Patient's Telephone: _____

Language _____

Staff Verification

Time in: _____ am/pm Time out: _____ am/pm

Verified By: _____ Verified By: _____

Phone extension: _____ Phone extension: _____

Every 3 hours contracted/agency interpreters need to call 566-3256 and 899-6666 to check in with the Interpreting Services to verify if services are still needed.

All questions or concerns should be addressed to:

Office of Interpreting Services
Riverside/Grant Hospital
566-3256 24/7 Interpreter Hotline

Fax: 566-6910 with 24hr advance notice
Emergency pager 842-0427

Information on this form is considered confidential and law strictly prohibits any disclosure

Office Use Only:

Confirmed By: _____

Date: _____

Comments: _____