Interpreting Network of the Eastern Shore

An Independent Program of

DILA Deaf Independent Living Association, Inc.

INTERPRETER REQUEST

Today's Date: _____ Request Taken By: _____

Contact Person (Doctor's Office): _____ Telephone # & Ext.: _____

Date of Appointment: _____ **Time:** _____

Service provided for (name of deaf & hearing client): _____

Select consumer's mode of communication: ☐ ASL ☐Gestural/MLS ☐Low-Vision ☐SEE/PSE ☐Tactile

Place of appointment (Full name and Address)

_____

_____

Purpose: _____

Other related information (directions, agenda, etc.): _____

_____

BILLING INFORMATION (Name and address of responsible party)

_____

_____

_____

FOR DILA OFFICE USE ONLY:

Interpreters Contacted: ☒Yes ☐No Date Contacted: _____ Initials: _____ Funding Source: _____

RATE TYPE: (check one) ☐Day ☐Evenings/Weekend/Emergency ☐Legal

Hours: _____ Mileage: _____ Incidentals: (check one) ☐Approved ☐Not Approved

Interpreter Assigned: _____ Interpreter Assigned: _____

Date Requester Notified: _____ ☐ Filled ☐Not Filled Initials: _____

Comments:

Date Assignment Cancelled: _____ Who Cancelled: _____ Billable: ☐Yes ☐No

Interpreter Notified: ☐Yes ☐No Date: _____ Initials: _____ Rescheduled: ☐Yes ☐No (See comments)

Revised June 2018
Revised July 2017