

Interpreter Worksheet

Interpreters must submit completed worksheet **WITHIN 48 HOURS**

Please fax worksheets to 1-800-686-6315

INTERPRETER:

Interpreter ID #: _____

Interpreter Name: (print clearly) _____ Language: _____

Interpreter Signature: _____ Date: _____

PROVIDER:

Appointment Date: _____ Appointment Time: _____ AM / PM

Clinic Name: _____ Department: _____

Inpatient Dialysis

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: (_____) _____ - _____

PATIENT/CLIENT:

Last Name: _____ First Name: _____

DOB: _____ Gender: Female Male MR#: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: (_____) _____ - _____

Insurance: Blue+ Health Partners UCare None
 Other: Specify _____ Member ID #: _____

MUST BE COMPLETED by Medical Provider/Staff:

Date: _____ Start Time: _____ AM / PM End Time: _____ AM / PM

If more than 2 hours, how many? _____ hrs **REMINDER: Interpreters cannot work for more than 8 hours.**

Appointment Status (circle one): Completed Cancellation Same Day Cancellation Patient No Show

Overall quality of interpreter: Excellent Average Poor (please specify)

Comments: _____

Staff Name: _____ Staff Signature: _____ Date: _____

Office Use Only:	
<input type="checkbox"/> B+ <input type="checkbox"/> HP <input type="checkbox"/> UC <input type="checkbox"/> Clinic	