



LANGUAGE ACCESS INTERPRETER SERVICES (LAIS) REQUEST/CONFIRMATION/CANCELLATION

Refer to WRHA Policy 10.40.210

FAX: 204-940-8650 (Monday–Friday 0800–1500 hours)
24/7 Central Intake: 204-788-8585

CLIENT HEALTH RECORD #
CLIENT SURNAME
CLIENT NAME
DATE OF BIRTH
GENDER
PROVINCIAL HEALTH CARD #
PHIN
PHONE/CONTACT #

PRIMARY LANGUAGE:		CLIENT REQUESTED SPECIFIC GENDER OF INTERPRETER:	
OTHER LANGUAGE(S):		<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE <input type="checkbox"/> NO PREFERENCE	
REQUESTOR INFORMATION	NAME OF REQUESTOR: (Print YOUR Full Name)		NAME OF REQUESTING SITE: (Facility, Program, Agency, Office, etc.)
	DEPARTMENT NAME: (If applicable)		
	PHONE #:	FAX #:	ADDRESS:
APPOINTMENT INFORMATION (Use separate form for each appointment)	APPOINTMENT IS WITH: (Print Full Name & Title of Service Provider & Program/Department Name)		SERVICE PROVIDER (SP) CONTACT NUMBERS
	ADDRESS & ROOM # / LOCATION: (e.g. Children's Hospital, 840 Sherbrook Street, Purple Bear Zone)		OFFICE #:
	DESCRIPTION / PURPOSE: (e.g. breast cancer - to discuss medication and potential side effects)		FAX #:
	APPOINTMENT DATE:		CELL #: (Required for <u>all</u> Home Visits)
	ALTERNATE DATE:		
	DAY: e.g. Monday, Thursday DATE: D D M M M Y Y Y Y TIME: 24 HOUR DURATION:	Day: e.g. Monday, Thursday Date: D D M M M Y Y Y Y Time: 24 HOUR Duration:	
LAIS Interpreter has verbally accepted to interpret? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please print full name of Interpreter _____			
SERVICE REQUIRED	SELECT (✓) ALL THAT APPLY: <input type="checkbox"/> Over-the-Phone (OTP) <input type="checkbox"/> Message Relay <input type="checkbox"/> Face-to-Face (in person) <input type="checkbox"/> Conference Call <input type="checkbox"/> Reminder Call <input type="checkbox"/> Home Visit (See SP Contact #s) <input type="checkbox"/> Video Conference <input type="checkbox"/> MB Telehealth		
ADDITIONAL INFORMATION	CANCELLATION <input type="checkbox"/> Cancel appointment – no further action required. <input type="checkbox"/> Cancel appointment – inform client. <input type="checkbox"/> Cancel appointment and reschedule to: DATE: D D M M M Y Y Y Y TIME: 24 HOUR DURATION:		
CONFIRMATION Internal LAIS Use Only	DAY OF APPOINTMENT To be completed by Service Provider (SP) Start Time: 24 HOUR End Time: 24 HOUR Duration: hours mins Actual Appointment Time different from scheduled time? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason: <input type="checkbox"/> Interpreter <input type="checkbox"/> Late <input type="checkbox"/> Client <input type="checkbox"/> No Show <input type="checkbox"/> SP <input type="checkbox"/> Other _____ Service Provider Signature Interpreter Signature		

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