Allina Hospitals & Clinics

AGENCY INTERPRETER WORKSHEET AND FEEDBACK FORM

Interpreter: *Please coomplete this section before you begin your appointment and hand it to the Healthcare Professional when you introduce yourself.*

APPOINTMENT INFORMATION: Date:____________________________

FACILITY: □ UH □ Abbott NW □ Mercy □ Coon Rapids □ Unity □ Other: _______________

UNIT: □ Surg. □ Emer. □ Labor/Del. □ Breast Center □ Sr. Kenny Other: _________________________

PATIENT'S LAST NAME: ________________________________ **FIRST NAME:** ____________________________

INTERPRETER NAME: ________________________________ **LANGUAGE:** ____________________________

AGENCY NAME: ____

Interpreter: do not write below this line

-------------THIS SECTION TO BE COMPLETED BY HEALTHCARE PROFESSIONAL.------------

Instructions for Healthcare Professional: *Please check one of the answers box "Yes" or "No" provided and add "Comments".*

APPOINTMENT: Scheduled Time: __________ Arrival Time ____________ End Time ____________

If late, were you notified? □ NO □ YES, by whom?_________________________________

DID THE INTERPRETER ACT PROFESIONAL? □ YES □ NO

DID THE INTERPRETER COUNSEL, ADVISE, OR INTERJECT HIS/HER OPINION DURING THE INTERPRETATION? □ YES □ NO

WERE YOU ABLE TO COMMUNICATE EFFECTIVELY? □ YES □ NO

DID THE INTERPRETER REMAIN IN HIS/HER ROLE? □ YES □ NO

DID THE INTERPRETER HAVE A PROFESSIONAL APPERANCE? □ YES □ NO

OVERALL: Was interpreter performance: □ Excellent □ Good □ Average □ Poor

COMMENTS: ____

COMPLETED BY: ________________________________ **DATE:** ______________________________
(PLEASE PRINT)

TELEPHONE NUMBER: ___________________________________ **MAIL STOP:** _________________________

For deaf and hard of hearing patients, please inform the patient or companion that they may request proof of the interpreter qualification from either the interpreter or Allina Interpreter Services 612-775-8675

Interpreter: to receive payment for this assignment, please submit the whole sheet to your agency.

Thank you!