



LANGUAGE ACCESS INTERPRETER SERVICES (LAIS)

## REQUEST/CONFIRMATION/CANCELLATION

Refer to Shared Health Policy 350.140.123

FAX: 204-940-8650 (Monday-Friday 0800-1600 hours)

CALL: 204-788-8585 (24/7 Central Intake)

CLIENT MEDICAL RECORD #
CLIENT SURNAME
CLIENT GIVEN NAME
DATE OF BIRTH
GENDER
FAMILY REGISTRATION NO.

PHONE/CONTACT #

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Primary Language:			Client Requested Specific Gender of Interpreter:			
Other Language(s):				☐ Female ☐ Male ☐ No Preference		
	Name of Requestor: (Print YOUR Full Name)			Phone:	Fax:	
œ Z						
DE SE	Email (if you would like to receive interpreter booking confirmation by email):					
REQUESTOR INFORMATION	Name of Requesting Site: (Facility, Program, Agency, Office, etc.)			Department Name: (If applicable)		
E F	trains of requesting sites (rasimly, riegian, righting, cines, ste.)			- Spanner (a. spanner)		
<u>" ≤</u>	Address:					
	Appointment is with: (Print Full Name & Title of Service Provider & Program/Department Name)			Service Provider (SP)		
7 ~					Contact Numbers Office #:	
TIO	Address & Room # / Location: (e.g. Children's Hospital, 840 Sherbrook Street, Purple Bear Zone)				OINCE #.	
MA					Fax #:	
FOR ich ap	Description / Purpose: (e.g. breast cancer - to discuss medication and potential side effects)					
APPOINTMENT INFORMATION (Use separate form for each appointment)				Cell #: (Required for all Home Visits)		
	Appointment Date:  Alternate Date: (if available)					
NTN	Day: Date: Date: Day: Day: Date:					
Sep.	SPECIFY DAY OF THE WEEK D D M M M Y Y Y Y SPECIFY DAY OF THE WEEK D D M M M Y Y Y Y  Time:           Duration: Time:         Duration:					
API (Use	Time:          Duration:          Duration:            24 HOUR         24 HOUR				Duration:	
	LAIS Interpreter has verbally accepted to interpret?  UNO  If yes, please print full name of Interpreter					
	accepted to interpret:					
ᄪᇛ	Select (✓) all that apply: ☐ Conference Call *Please note in 'Additional Information' the ☐ Reminder Call			☐ External Contract Provider		
N N N	☐ Face-to-Face (in person)  phone number the interpreter must call on the appointment date  ☐ Message Relay  ☐ Video Conference*				(Over-the-Phone - OTP)	
SER	Home Visit (See SP Contact #s)  ☐ MB Telehealth					
	*Video conference link must be emailed to languageaccess@sharedhealth	opointment date.				
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z ≥		z	Cance	l appointment – no further action required.		
CONFIRMATION nternal LAIS Use Only	☐ Interpreter Assigned:	ANCELLATION		l appointment – inform client.		
RMA US Us		LLA		edule to: Day:	Date:	
AFIF Pal LA	☐ Interpreter Not Available	CE		SPECIFY DAY OF THE WEEK	D D M M M Y Y Y Y	
nte m	☐ Access OTP	Ä		Time: LILL Durat	ion:	

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