



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH

LANSING

JENNIFER M. GRANHOLM  
GOVERNOR

JANET OLSZEWSKI  
DIRECTOR

**Early Hearing Detection and Intervention Program  
Intervention Status Follow-Up Form  
Hearing Loss Identified**

Date:			FAX:		
To:			County <i>Early On</i> ®Michigan Coordinator		
From: Michelle Garcia, EHDI Follow-Up Consultant, 517-335-8878					
RE:			DOB:		
DX Hearing Loss:					
<b>Early On Services:</b>					
Already enrolled in EO system?	Yes	No	First Enrollment Date:		
Parents refused EO services?	Yes	No			
Other disabilities identified?	Yes	No			
<b>Educational Intervention:</b>					
Coordinating Interventionist's name:			Phone:		
School System:					
A person with HI experience on the IFSP?	Yes	No			
<b>Audiological Intervention:</b>					
Coordinating Audiologist's name:			Phone:		
Audiologic monitoring every 3 months?	Yes	No			
Amplification option chosen?	Yes	No	Fit date:		
Amplification monitored every 3 months?	Yes	No			
Cochlear Implant option chosen?	Yes	No			
<b>Communication Skills Intervention:</b>					
Parent-Infant Program?	Yes	No			
<b>Family Support:</b>					
Resource guide distributed? (Form # MDCH-0376)	Yes	No	Date: (for copies 517/335-9560)		
Community Mental Health Services?	Yes	No			
Children's Special Health Care Services?	Yes	No			
Family-to-Family Support Referral?	Yes	No	(EHDI Parent Consultant 517/335-8273)		
<b>Medical Intervention:</b>					
Coordinating Physician:			Phone:		
Risk indicator for hearing loss identified?	Yes	No	Risk Indicator:		
Physician involved in IFSP?	Yes	No			
Otolaryngology evaluation?	Yes	No	Referral in process?	Yes	No
Ophthalmology evaluation?	Yes	No	Referral in process?	Yes	No
Genetic evaluation? Clinic?	Yes	No	(for MDCH Genetics 517/335-8887)		

I hereby give my permission to the Early On staff to release this intervention information to the MDCH/EHDI. I understand that MDCH/EHDI uses this information to help ensure that my child receives appropriate services. MDCH/EHDI uses unidentified combined intervention information to help improve statewide services.

Parent signature:	Date:
<b>FAX BACK TO 517/335-8036 by:</b>	Date Faxed Back:

(11/4/03)