STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ROBERT GORDON
DIRECTOR

Early Hearing Detection and Intervention Program

TO: Early On Coordinator	**DATE:**
County: *Early On*® Michigan Coordinator	**PAGES (including this one):**
FAX NO.	
FROM: Michelle Garcia Follow-up Consultant	**PHONE NO: 517-335-8878**
AGENCY: Early Hearing Detection and Intervention Program	**FAX NO. 517-763-0183**

Attached is a referral for a child identified with hearing loss. If this child is unknown to you, please contact the diagnostic center and discuss how collaboration between sites can be improved.

Please ensure that the Early On Service Provider assigned to this case completes and returns the attached Intervention Status Follow-Up Form. **At minimum ensure the signed IFSP date is documented.** This form allows us to verify that early intervention services were offered to the family and helps us improve statewide services for infants and children identified with hearing loss.

If authorization to share with EHDI is not attached, please be sure to get consent to share with EHDI on the EHDI Intervention Status Follow-Up Form (attached), or the Early On Authorization to Share Form.

If you have any questions, please do not hesitate to contact me. Thank you for serving Michigan's Children!

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Early Hearing Detection and Intervention Program

Hearing Intervention Status Form: Child with Hearing Loss Identified

FAX:			Date:		
To: *Early On*® Coordinator					
From: Michelle Garcia, EHDI, Follow-Up Consultant, 517-335-8878					
RE:	DOB:		Kit Number:		
Hearing Loss:					
Early On Services:					
Already enrolled in EO system?	Yes	No	IFSP Signed Date:		
Parents refused EO services?	Yes	No			
Other disabilities identified?	Yes	No			
Educational Intervention:					
Coordinating Interventionist's name:			Phone:		
School System:					
A person with HI experience on the IFSP?	Yes	No			
Audiological Intervention:					
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			
Communication Skills Intervention:					
Parent-Infant Program?	Yes	No			
Family Support:					
Resource guide distributed?	Yes	No	Date: (for copies 517-335-8955)		
Community Mental Health Services?	Yes	No			
Children's Special Health Care Services?	Yes	No			
Family-to-Family Support Referral?	Yes	No	(Guide By Your Side 248-514-9616)		
Medical Intervention:					
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 MDHHS Genetics 517-335-8887)		

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

Parent signature:	Date:
FAX BACK TO 517-763-0183 by:	Date Faxed Back: