



STATE OF MICHIGAN

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

Early Hearing Detection and Intervention Program

TO: Early On Coordinator	DATE:
County:	PAGES (including this one):
FAX NO.	
FROM: Michelle Garcia Follow-up Consultant	PHONE NO: 517-335-8878
AGENCY: Early Hearing Detection and Intervention Program Michigan Department of Health and Human Services	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!

IMPORTANT NOTICE: Confidentiality Notice: The documents contain information from the Michigan Department of Health and Human Services, which is confidential in nature. The information is for the sole use of the intended recipient(s) named on the coversheet. If you are not the intended recipient, you are hereby notified that any disclosure, distribution or copying, or the taking of any action in regard to the contents of this information is strictly prohibited. If you have received this fax in error, please telephone us immediately so that we can correct the error and arrange for destruction or return of the faxed document.

Authority: Title XIX of the Social Security Act
Completion: Voluntary
Penalty: None
FILE: FAXSHEET

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Early Hearing Detection and Intervention Program Hearing Intervention Status Form: Child with Hearing Loss Identified

FAX:			Date		
To:					
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? (Form # MDHHS-0376)		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:	