Connecticut Early Hearing Detection & Intervention (EHDI) Program (860) 509-8251

Family Plan of Care for Infants\Children Who are Deaf or Hard of Hearing

Patient Information

Child's Last Name:_____First:_____ DOB:_____

Child's Address: _____City: _____ State:_____ Zip_____

Guardian's Name:_____ Relationship to Child:_____

Guardian Primary Phone:_____ Email:_____ Secondary Phone:_____

Medical Summary

Diagnosis

Diagnosis:_____ **Date:**_____

Diagnosis:_____ **Date:**_____

Diagnosis:_____ **Date:**_____

Medications/Supplements

1. _____ **2.** _____

3. _____ **4.** _____

5. _____ **6.** _____

Surgeries

Surgery:_____ **Date:**_____

Surgery:_____ **Date:**_____

Surgery:_____ **Date:**_____

Allergies

1. _____ **2.** _____

3. _____ **4.** _____

5. _____ **6.** _____

Hearing-Related Care Team

Role	Name	Best way to contact	
Family member(s)		Phone:	Email:
Pediatrician\PCP		Phone:	Email:
ENT		Phone:	Email:
Audiologist		Phone:	Email:
B23 Coordinator		Phone:	Email:
Other:		Phone:	Email:

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Family Checklist (Medical Home)

Before 1 Month

☐ **Final Newborn Hearing Screening Results (OAE\ABR):** Date: _____

Left Ear:		Right Ear:
☐	**Pass**	☐
☐	**Did Not Pass\Refer** (Must also screen for CMV before 21 days of age)	☐
☐	**Not Tested**	☐

Birth Hospital, Midwife, or Provider that conducted the hearing screenings: _____.

☐**Cytomegalovirus (CMV) Screening Results:** Date: _____

☐Detected ☐Not detected

Birth Hospital, Midwife, or Provider that conducted the CMV screenings:_____.

Before 3 Months

To locate a pediatric audiologist near you, visit **www.ehdi-pals.org**

☐**Pediatric Diagnostic Audiology Evaluation (most recent):** Date: _____

Left Ear - Type\Degree of Hearing Loss: _____.

Right Ear - Type\Degree of Hearing Loss: _____.

☐Received copy of the hearing evaluation from audiologist. Date: _____

☐**Referred or self-referred to Birth to Three.** Call 1-800-505-7000. Date: _____

☐Pediatric ENT for medical clearance and further testing. Date: _____

☐**Recommended by 3-6 months:**

☐Hearing aid fitting. Date: _____

☐Ongoing diagnostic monitoring, as needed Date: _____

☐Family referred to Connecticut Family Support Network 1-877-FSN-2DAY. Date: _____

Before 6 Months

☐**Enrollment in Birth to Three (Early Intervention, IDEA, Part C).** Date: _____

Birth to Three supports families to enhance their child's development and connect to their communities. Early Intervention Programs bill public and private insurance and when applicable fees are charged based on a sliding scale. Anyone can refer a child by calling 1-800-505-7000. Visit www.birth23.org to learn more.

☐Receiving any other intervention/therapy services: _____.

☐Ongoing audiological testing to monitor hearing aids and progression of hearing loss.

☐**Medical Evaluations to determine causes and identify related conditions (ongoing):**

☐Ophthalmology (annually). Date: _____

☐Genetics. Date: _____

☐Other specialists (as needed): _____. Date: _____

☐**Other tests to consider**: CT, MRI, EKG, or Ultrasound. Speak with your provider.

Risk Factors for Hearing Loss

Check all the apply (continue monitoring hearing if present):

☐None Known
☐Caregiver Concern
☐Craniofacial Anomalies
☐Cytomegalovirus (CMV)
☐Cultural Positive Postnatal Infections
☐Family History
☐Head Trauma
☐Hyperbilirubinemia
☐In-utero Infections
☐Neurodegenerative disorder
☐NICU >5 days
☐Ototoxic Medications
☐Physical Findings
☐Syndromes – Specify: _____

Next Steps:

Need Help with this Form or need more copies?
Call: 860-509-8251 and ask for the EHDI program. For, visit us at us at **https://portal.ct.gov/ehdi**

Parent Support: If your child has a hearing loss, contact the Connecticut Family Support Network for free parent support and guidance at: www.CTFSN.org or 1-877-FSN-2DAY.

Feedback: You comments and suggestions are valuable to us. Please send them to: **dph.ehdi@ct.gov**.

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