

<p><b>North Hawai'i Child Development Program</b>  <b>75-5769 Kuakini Hwy. #203</b>  <b>Kailua-Kona, HI 96740</b></p>
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To:	From:
Date:	Re: Your Patient: <span style="float: right;">DOB:</span>

Your patient has been assessed and is eligible for early intervention services from our program. I have been designated as the child and family's care coordinator.

**As Care Coordinator I**

- Share responsibility with the family
- Work with the family to identify their strengths and concerns
- Assist the family in obtaining and coordinating services from our program and other community resources
- Help the family identify professionals like *you*, their PCP, and family members and others to be part of an early intervention team.
- Maintain communication with all team members.
- Facilitate development of the Individual Family Support Plan (IFSP) at team meetings.
- Facilitate development of a transition plan when the child turns three.

We have scheduled the IFSP meeting, and we would appreciate any input you have. If you are able to attend the meeting, please call to confirm the date and time. If you are unable to attend, you may use the attached 2 pages to provide input. Please fax it to me (808-885-8054) at least 2 days before the meeting, and I will share it at the meeting. Or, you can call me at 808-885-0086 x18 to give me your input.

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Location: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Sincerely,

\_\_\_\_\_  
 Care Coordinator

Attachment

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# Confidential Fax

**To:** North Hawai'i Child Development Program **Fax:** 808-885-8054

Attn: \_\_\_\_\_

**From:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Re Patient:**

(DOB: \_\_\_\_\_)

**Pages:** \_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Should you have difficulties or questions receiving this transmission, please call sender at 808-885-0086 x18.**

**Patient Name:** \_\_\_\_\_ **(DOB** \_\_\_\_\_ **)**

**Input for Individual Family Service Plan from** \_\_\_\_\_  
**(Physician)**

\_\_\_\_\_  
**(Date)**



I do not have any concerns at this time.

Medical/other concerns listed below: