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,

[signature]

Care Coordinator

Attachment
Confidential Fax

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

Attn:

From:  Date:

Re Patient:  Pages:

(DOB: _________)

COMMENTS:________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

NOTICE: The contents of this fax transmission are intended only for the use of the individual or entity to which it is directed. This document may contain information that is privileged, confidential and exempt from further disclosure. If you are not the addressee of this transmission, you are not authorized to read the contents of this message and you are hereby notified that any dissemination, distribution or copying of this transmission are strictly prohibited by federal and state laws. If this transmission has been received by you in error and delivery to the intended recipient is not promptly possible, we would appreciate notification by telephone and return of the original transmission to us via the U.S. Postal Service immediately. We appreciate your cooperation.

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:

______________________________