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.

The next step is to hold a meeting to create the Individualized Family Support Plan (IFSP). The IFSP is:

- A document which lists the child and family’s strengths and areas in which they need support and/or therapy.
- Created by a team including the family, myself, any extended family members, friends, and/or advocates who the family chooses to invite, and other professionals who work with the child and/or family, ideally including **you**, the PCP.
- A plan which uses short- and long-term objectives to help gauge progress.

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 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
Confidential Fax

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

Attn: 

From: 

Date: 

Re Patient: (DOB: ____________)  Pages: 

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: