

**West Hawai`i Public Health Nursing Program
79-1015 Haukapila St.
Kealahou, HI 96750**

To:	From:
Date:	Re: Your Patient: DOB:

It is time to review the Individualized Family Support Plan (IFSP) for your patient. We would appreciate any input you have. If you are able to attend the IFSP 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 (808-322-1504) at least 2 days before the meeting. Or, you can call me at 808-322-1500 to give me your input.

Date: _____
 Time: _____
 Location: _____

Fast Fact

Fifty percent of 2-year-olds who do not use at least 50 words will not "grow out of it" by the time they start school. Early intervention services can help!



To refer a child for a free assessment,
call H-KISS, 800-235-5477.

Attachments



Confidential Fax

To: W. HI Public Health Nursing Section Fax: 808-322-1504

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 808-322-1500.

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: