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: 

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**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.
Confidential Fax

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

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 808-322-1500.
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: