

# Learning about Hearing Loss-A Roadmap for Kentucky Families

NAME: _____	CUP ID: _____
DATE: _____	PHONE: _____
CHILD: _____	CHILD BIRTHDAY: _____

DIAGNOSIS OF HEARING LOSS	DURING THE FIRST TWO WEEKS	WITHIN THE FIRST MONTH
<input type="checkbox"/> Evaluation completed by an audiologist Date of Diagnosis: ____/____/____ Place: _____  Hearing Loss Diagnosis Left Ear: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Profound  Right Ear: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Profound  <b>Referrals:</b>  <input type="checkbox"/> Early Intervention (EI)-Children with permanent hearing loss may be eligible for these family focused services. Your EI Team may include a teacher for deaf and hard of hearing, an audiologist, speech pathologist with experience in working with deaf/hard of hearing infants, health care providers and family members.  <input type="checkbox"/> Other families of children with hearing loss for parent-to parent support-Hands and Voices of Kentucky-Non-Biased Support for families of children who are deaf and hard of hearing.  <b>Communication:</b>  <input type="checkbox"/> Child's Primary Care Provider  _____	<input type="checkbox"/> Received packet of information mailed to family from F2F parent consultants  <input type="checkbox"/> Discuss your child's hearing loss with your health care provider at your child's next well child checkup or make an appointment.  <input type="checkbox"/> Further testing needed:  Place: _____ Date: ____/____/____ Time: _____  <b>Additional Information Needed:</b> _____ _____ _____ _____ _____ _____	<input type="checkbox"/> Your Healthcare Provider or Audiologist will help you coordinate referrals to recommended specialists (ENT, Genetics, Ophthalmology)  <input type="checkbox"/> ENT Evaluation (Medical Clearance for Hearing Aids if chosen) Place: _____ Date: ____/____/____  <input type="checkbox"/> Genetics Evaluation Place: _____ Date: ____/____/____  <input type="checkbox"/> Ophthalmology Evaluation Place: _____ Date: ____/____/____  <input type="checkbox"/> Hearing Aid Fitting (if chosen) Place: _____ Date: ____/____/____  <hr/> <p style="text-align: center;"><b>AFTER THE FIRST MONTH</b></p> <input type="checkbox"/> Ongoing Audiology care and hearing aid evaluations at three to six month intervals or as needed. Earmolds may be needed more frequently. <input type="checkbox"/> After an EI Evaluation is completed, an Individualized Family Service Plan (IFSP) will be completed for eligible children and their families. <input type="checkbox"/> Your health care provider/audiologist will help coordinate referrals to recommended specialists if not already completed.