RIEHDI
Rhode Island Early Hearing Detection and Intervention

SHARED PLAN OF CARE

Child's Name: _____

DOB: _____ ☐ Male ☐ Female

Parent/Guardian Name(s): _____

Address: _____

City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Preferred method of communication: home phone cell phone/text email: _____

Primary Language(s) used at home: _____

Is an Interpreter Needed: Y / N If Yes, Specify Language: _____

Alternate Contact: _____ Relationship: _____

Cell phone/Home phone _____

Caregivers (in addition to parent/guardian – i.e., daycare, early head start, etc.)

Caregiver Name	Role/Relationship	Contact Information

Last Updated [date]: _____

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Medical Summary

Hearing Loss Information

	Type	Degree	Technology	Audiogram Attached (Y or N)
Right Ear				
Left Ear				

Other Medical Issues: _____ _____

_____ _____

_____ _____

Medication(s) list attached : Y or N

Communication Strategies

Currently used:

☐ American Sign Language (ASL)

☐ Auditory Oral

☐ Auditory Verbal

☐ Augmentative and Alternative Communication

☐ Total Communication

Want more information about:

☐ American Sign Language (ASL)

☐ Auditory Oral

☐ Auditory Verbal

☐ Augmentative and Alternative Communication

☐ Total Communication

Other strategies used (if any):_____

Last Updated [date]: _____

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Assistive technologies:

FM: Y / N

Other Assistive Technology: _____

Providers

My Medical Team

Specialty:	Name	Contact Info	Last Visit Date	Upcoming Appt. Date	Most Recent Report/Evaluation Date	✓
PCP/Pediatrician						
Audiologist						
Ears, Nose & Throat (ENT)						
Geneticist						
Ophthalmologist						
NICU Follow/Up						
Other						
Other						
Other						
Other						

* Please ✓ if Evaluation/Report is included

My Family Support

Specialty:	Name	Agency	Contact Information
Parent Resource Specialist			
Social Worker			
Case Manager			

Last Updated [date]: _____

DCYF			
Family Visiting			
Other			
Other			

My Early Intervention Team: **Agency: _____** **Ph.: _____**

Specialty:	Name	Phone (Mobile)	e-mail	Date added to IFSP	Evaluation/Assessment Date Completed	✓
Service Coordinator						
Educator						
Speech Language Pathologist						
Physical Therapist						
Occupational Therapist						
Other						
Specialized Services:	Name	Contact Info	Role	Enrollment Date	Evaluation/Report	
Northern RI Collaborative						
Perspectives Corp.						
RI Sign Language Initiative						
Parent Infant Partners						
Other						

* Please ✓ if Evaluation/Assessment is incl

Last Updated [date]: _____

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PLAN OF CARE

Area of Focus (i.e., Language development, social/emotional development, etc.)	Goal	Strategies/Action Items	Person(s) Involved	Resolution
				□ In Process □ On Hold □ Completed □ Discontinued
				□ In Process □ On Hold □ Completed □ Discontinued
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