HEALTH CARE PROVIDER INFORMATION

TO: _____
_____
_____

DATE: _____

PLEASE RETURN THIS FORM TO:
Shiawassee *Early On®*
Attn: _____
Fax 989-725-1312

Enclosed please find a signed ***Great Start Interagency Request for Protected Health Information*** for the following child:

_____ _____
(Name) (Date of Birth)

This child and family are either receiving or in the process of being considered for *Early On®* services. As part of the process to determine eligibility, an Individualized Family Service Plan (IFSP) may be developed and your input to the following is extremely important:

1) When was this child last seen in your office? _____
(Date)

2) List any established diagnosis and/or possible developmental delays (i.e., asthma, GERD, syndromes, etc.) and date of diagnosis.

_____ _____
(Diagnosis/Developmental Delay) (Date)

_____ _____
(Diagnosis/Developmental Delay) (Date)

3) Is the condition likely to: ❒ Progress ❒ Be Stable ❒ Improve

4) Does the child have any delays in the following (check all that apply)?
❒ Communication ❒ Cognition ❒ Gross Motor ❒ Socialization ❒ Fine Motor

5) Did/Does the child have any of the following (check all that apply & give date)?

-Hearing Screened	❒ Yes ❒ No	If yes, list date:	_____
-Vision Screened	❒ Yes ❒ No	If yes, list date:	_____
-Known or Suggested Allergies	❒ Yes ❒ No	If yes, list:	_____
			_____
-Medications	❒ Yes ❒ No	If yes, list:	_____
			_____
-Elevated Venous Blood Lead Level	❒ Yes ❒ No	If yes, list	_____

6) Are immunizations current? ❒ Yes ❒ No

Comments/Concerns: _____
_____
_____
_____ _____
(Signature) (Date)

Shiawassee Early On®
114 W. North St., Ste. 1, Owosso, MI 48867
Phone 989-725-2581 or 1-866-725-7792
Fax 989-725-1312