INFORMATION EXCHANGE:
Supporting the Child with a Cochlear Implant

Parent • CI Center • School • Therapist • Early Interventionist • Physician

The purpose of this form is to assist communication among individuals who assist the child who has a cochlear implant(s) or his or her family members. Please keep a copy of this form at each location where the child receives services. Use the progress form to evaluate and monitor performance that may assist with programming adjustments. When questions or concerns arise, please contact the CI Center immediately.

(monthly) (quarterly) (biannual) updates among all support individuals are recommended.

I am giving permission for the individuals below to exchange information about my child:

Parent/Guardian Signature: _____ Date Signed: _____

Parent Name: _____ Phone#: _____

CHILD INFORMATION

Date completed: _____

Name: _____ DOB: _____ AGE: _____

Cochlear Implant Make/Model: _____ Activation Date(s) _____

Right ear device(s): _____ Serial#: _____

Left ear device(s): _____ Serial#: _____

EARLY INTERVENTION PROVIDER / SCHOOL DISTRICT PERSONNEL

Primary Contact: _____ Title: _____

Address: _____

Phone: _____ Email: _____ Fax: _____

Best time to contact: _____ Best way to contact: □ Phone □ Email □ Fax

School or EI Program Name: _____

Teacher(s) / EI Provider(s): _____

Email / Phone (if different from above): _____

School/Clinical Audiologist: _____ Email: _____

COCHLEAR IMPLANT CENTER

Center Name: _____ Audiologist: _____

Address: _____

Phone: _____ Email: _____ Fax: _____

Best time to contact: _____ Best way to contact: □ Phone □ Email □ Fax

PRIMARY MEDICAL CARE PROVIDER

Center Name: _____ Physician: _____

Address: _____

Phone: _____ Email: _____ Fax: _____

Best time to contact: _____ Best way to contact: □ Phone □ Email □ Fax

ANY ADDITIONAL THERAPY OR SERVICE PROVIDER

Name: _____ Center: _____

Address: _____

Phone: _____ Email: _____ Fax: _____

Best time to contact: _____ Best way to contact: □ Phone □ Email □ Fax

The purpose of this form is to assist communication among individuals who assist the child who has a cochlear implant(s) or his or her family members. Parent, please give this checklist to the people who support your child's learning and development and return it in the enclosed envelope to:

Return this checklist to: _____

Date completed:_____ **Person Completing Form:**_____

Child's name: _____ **DOB:**_____ **AGE:**_____

Communication approaches used by the family with the child: □ speaking □ gestures □ other_____ □ listening training □ fingerspelling □ speech reading □ English word order signing □ cued speech □ American Sign Language	Always	Usually	Sometimes	Occasionally	Never/ Rarely
1. Child tolerates wearing the implant _____ hour(s)					
2. Daily monitoring checks of the implant occur					
3. Implant appears to be working properly					
4. Implant is worn daily on a consistent basis					
5. Child responds to environmental noises					
6. Child seems annoyed by background noise.					
7. Child responds to his/her name.					
8. Child puts on cochlear implant independently.					
9. Regularity of attendance (therapy, school, etc.)					
10. Observe increase in speech production skills.					
11. Observe increase in oral language use.					

			Not Observed		
The child appears to:	**Disagree**		**No change**		**Agree**
1. Be more aware of my voice	(-2)	(-1)	(0)	(1)	(2)
2. Be more aware of environmental sounds	(-2)	(-1)	(0)	(1)	(2)
3. Search more readily for the location of my voice	(-2)	(-1)	(0)	(1)	(2)
4. Have responded to new sounds or at new distances	(-2)	(-1)	(0)	(1)	(2)
5. Have an increased amount of babbling or talking	(-2)	(-1)	(0)	(1)	(2)
6. Have more interest in communicating	(-2)	(-1)	(0)	(1)	(2)
7. Be making new sound confusions	(-2)	(-1)	(0)	(1)	(2)
8. Have sounds that he consistently does not hear	(-2)	(-1)	(0)	(1)	(2)
9. Be saying 'what' or 'huh' more often	(-2)	(-1)	(0)	(1)	(2)
10. Have speech that is quieter, louder, slushier	(-2)	(-1)	(0)	(1)	(2)

Please use a separate sheet of paper to comment or ask questions on child's progress, implant use and function.

PROGRAMMING SESSION:

Implant test/Impedance Testing Completed: _____ Results: _____

Threshold levels set with: ◯ BOA ◯ Conditioned Play ◯ Counting ◯ Estimated

Comfort Levels set with: ◯ ESRTs ◯ NRT ◯ Behavioral ◯ Estimated

Comments: _____

MAPs: Program Location: **P1** ____ Description: _____

P2 ____ _____

P3 ____ _____

P4 ____ _____

Recommended Settings: Program: Sensitivity: Volume:

INFORMATION EXCHANGE:
Supporting the Child with Hearing Aid(s)

Parent • Audiologist • School • Therapist • Early Interventionist • Physician

The purpose of this form is to assist communication among individuals who assist the child who has hearing aid(s) or his or her family members. Please keep a copy of this form at each location where the child receives services. Use the progress form to evaluate and monitor performance that may assist with programming adjustments. When questions or concerns arise about the child's auditory performance (listening ability), please contact the audiologist immediately.

(monthly) (quarterly) (biannual) updates among all support individuals are recommended.

I am giving permission for the individuals below to exchange information about my child:

Parent/Guardian Signature: _____ Date Signed: _____

Parent Name: _____ Phone#: _____

CHILD INFORMATION Date completed: _____

Name: _____ DOB: _____ AGE: _____

Hearing Aid Make/Model: _____ Fitting Date(s) _____

Right ear device(s): _____ Serial#: _____

Left ear device(s): _____ Serial#: _____

EARLY INTERVENTION PROVIDER / SCHOOL DISTRICT PERSONNEL

Primary Contact: _____ Title: _____

Address: _____

Phone: _____ Email: _____ Fax: _____

Best time to contact: _____ Best way to contact: □ Phone □ Email □ Fax

School or EI Program Name: _____

Teacher(s) / EI Provider(s): _____

Email / Phone (if different from above): _____

School Audiologist: _____ Email: _____

AUDIOLOGIST

Clinic Name: _____ Audiologist: _____

Address: _____

Phone: _____ Email: _____ Fax: _____

Best time to contact: _____ Best way to contact: □ Phone □ Email □ Fax

PRIMARY MEDICAL CARE PROVIDER

Center Name: _____ Physician: _____

Address: _____

Phone: _____ Email: _____ Fax: _____

Best time to contact: _____ Best way to contact: □ Phone □ Email □ Fax

ANY ADDITIONAL THERAPY OR SERVICE PROVIDER

Name: _____ Center: _____

Address: _____

Phone: _____ Email: _____ Fax: _____

Best time to contact: _____ Best way to contact: □ Phone □ Email □ Fax

Developed by the Florida Cochlear Implant Workgroup, 2006, based on a similar form by the Colorado Cochlear Implant Consortium.

The purpose of this form is to assist communication among individuals who assist the child who has hearing aid(s) or his or her family members. Parent, please give this checklist to the people who support your child's learning and development and return it in the enclosed envelope to:

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Date completed:_____ **Person Completing Form:**_____

Child's name: _____ **DOB:**_____ **AGE:**_____

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3. Implant appears to be working properly					
4. Implant is worn daily on a consistent basis					
5. Child responds to environmental noises					
6. Child seems annoyed by background noise.					
7. Child responds to his/her name.					
8. Child puts on cochlear implant independently.					
9. Regularity of attendance (therapy, school, etc.)					
10. Observe increase in speech production skills.					
11. Observe increase in oral language use.					

The child appears to:	**Disagree**		**Not Observed No change**		**Agree**
1. Be more aware of my voice	(-2)	(-1)	(0)	(1)	(2)
2. Be more aware of environmental sounds	(-2)	(-1)	(0)	(1)	(2)
3. Search more readily for the location of my voice	(-2)	(-1)	(0)	(1)	(2)
4. Have responded to new sounds or at new distances	(-2)	(-1)	(0)	(1)	(2)
5. Have an increased amount of babbling or talking	(-2)	(-1)	(0)	(1)	(2)
6. Have more interest in communicating	(-2)	(-1)	(0)	(1)	(2)
7. Be making new sound confusions	(-2)	(-1)	(0)	(1)	(2)
8. Have sounds that he consistently does not hear	(-2)	(-1)	(0)	(1)	(2)
9. Be saying 'what' or 'huh' more often	(-2)	(-1)	(0)	(1)	(2)
10. Have speech that is quieter, louder, slushier	(-2)	(-1)	(0)	(1)	(2)

Please comment or ask questions about the child's progress, hearing aid use and/or listening/life function: