

# 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: <input type="checkbox"/> speaking <input type="checkbox"/> gestures <input type="checkbox"/> other _____ <input type="checkbox"/> listening training <input type="checkbox"/> fingerspelling <input type="checkbox"/> speech reading <input type="checkbox"/> English word order signing <input type="checkbox"/> cued speech <input type="checkbox"/> 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.					

The child appears to:	Not Observed				
	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

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**Return this checklist to:** \_\_\_\_\_

**Date completed:** \_\_\_\_\_ **Person Completing Form:** \_\_\_\_\_

**Child's name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

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	Disagree	No change			Agree
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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:

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