

Keeping Track



The Keeping Track section is intended to provide you with a place to keep all of the information you are gathering about your child. In this section, you will find:

- ☺ A plastic business card holder - to keep the cards of professionals that are becoming part of your child's life. Many times the business cards also have appointment dates and times on them.
- ☺ Annual and Monthly Calendars - to write down and manage the many appointments you will have, medical, social, and other.
- ☺ At-a-Glance Appointment Record - designed by other parents to record information about upcoming appointments as well as develop a written history of key items from past appointments all in one place.
- ☺ Forms to Request from Providers - to help you get a sense of the medical records that you may want or need in the future. Collecting them as you go along may save you the time and effort of tracking them down later.
- ☺ Information Providers May Request From You - organizes the information regularly needed by medical providers, child care providers, family members and so on. Perhaps you will be able to give out copies of this form rather than re-writing this information over and over again.
- ☺ Plastic Sheet Protectors – provided for you to store your child's most recent hearing tests and IFSP's. A sheet protector is also available for health insurance information to be stored and easily located when needed.
- ☺ Note Pages – sometimes professionals may ask you to carry a message to another professional. Other times professionals may wish to keep a running dialog with one another. For example, the audiologist and the birth to three providers may want to communicate about how your child is using their hearing instrument. Blank pages are provided for you or the professionals you work with to record notes.

You may find that all of the organizational tools provided are useful just the way they are or you may wish to change them to better fit your style. In any case, they are meant to make life a little simpler. Don't forget to make photocopies of pages you find particularly useful!

**Insert Your Business Cards
into the Plastic Business Card Holder**

Annual Calendar



<u>January</u>	<u>February</u>
<u>March</u>	<u>April</u>
<u>May</u>	<u>June</u>
<u>July</u>	<u>August</u>
<u>September</u>	<u>October</u>
<u>November</u>	<u>December</u>

Annual Calendar



<u>January</u>	<u>February</u>
<u>March</u>	<u>April</u>
<u>May</u>	<u>June</u>
<u>July</u>	<u>August</u>
<u>September</u>	<u>October</u>
<u>November</u>	<u>December</u>

Annual Calendar



<u>January</u>	<u>February</u>
<u>March</u>	<u>April</u>
<u>May</u>	<u>June</u>
<u>July</u>	<u>August</u>
<u>September</u>	<u>October</u>
<u>November</u>	<u>December</u>



Monthly Calendar



Notes	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday



Monthly Calendar



Notes	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday



Monthly Calendar



Notes	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

***Note: This is the last copy of this document.
If you wish to have additional copies, please photocopy this page before you write on it.**



Appointment Record

Child's Name

Appointment Date / Time	Provider's Name and Address	Provider's Phone #	Reason for Appointment	Notes/Follow-up Instructions



Appointment Record

_____ *Child's Name*

Appointment Date / Time	Provider's Name and Address	Provider's Phone #	Reason for Appointment	Notes/Follow-up Instructions



Appointment Record

_____ *Child's Name*

Appointment Date / Time	Provider's Name and Address	Provider's Phone #	Reason for Appointment	Notes/Follow-up Instructions

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Checklist of Information to Request from Providers

The following is a list of documents pertaining to your child's hearing healthcare. You may wish to request copies of some or all of these from your child's healthcare providers. You may receive some of them only once, while others you will receive regularly. As a parent, you have the right to any medical records that pertain to your child. All you need to do is ask!

Type of Report	Provided by...
<input type="checkbox"/> Hearing Screening Results	Birth Hospital/ Primary Care Provider
<input type="checkbox"/> Hearing Evaluations	Audiologist
<input type="checkbox"/> Confirmation of Hearing Loss Report Form	Audiologist
<input type="checkbox"/> Hearing Instrument Recommendations	Audiologist
<input type="checkbox"/> Brochures: <i>Babies and Hearing Loss and Birth - 3</i>	Audiologist/Primary Care Provider
<input type="checkbox"/> Medical Records	Primary Care Provider
<input type="checkbox"/> Speech and Language Evaluations	Birth - 3/ Speech Language Pathologist
<input type="checkbox"/> Individualized Family Service Plan	Birth - 3
<input type="checkbox"/> Transition Plan	Birth - 3
<input type="checkbox"/> Other Evaluations: <i>(OT, PT, vision, genetics, etc.)</i>	



Information Providers May Request From You

Child's Information:

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Place of Birth (Hosp, City, State): _____

Siblings: Yes No Names/Ages: _____

Primary Family Language: _____

Parent/Guardian Information (Person(s) child lives with):

Father: _____ Phone: () _____

Address: _____ Apt/Lot Number: _____

Mother: _____ Phone: () _____

Address: _____ Apt/Lot Number: _____

Step-Parent: _____ Phone: () _____

Address: _____ Apt/Lot Number: _____

Father place of employment: _____

Hours: From _____ to _____ Work Phone: () _____

Mother place of employment: _____

Hours: From _____ to _____ Work Phone: () _____

Child's Emergency Information:

(Please list 2 additional persons that can be notified in case of an accident or illness in the event a parent cannot be contacted):

First Contact Name & Address: _____

Relationship: _____ Phone: () _____

Second Contact Name & Address: _____

Relationship: _____ Phone: () _____

If emergency treatment is required, and we are unable to reach either you or your emergency contacts, I authorize school personnel to call:

Physician: _____ Phone: () _____

Child's Insurance Information

Name of Insurance	Group/Policy #	Child's Social Security Number	Phone Number
			()
			()

Child's Medical Information

Title	Name	Address	Phone Number
Primary Care Provider			()
Audiologist			()
ENT			()
Other			()
Other			()
Other			()

Child's Early Intervention Information

Title	Name	Address	Phone Number
Service Coordinator			()
Therapist			()
Other			()
Other			()

Child's Amplification Information

Type of Amplification (Hearing Aids, Cochlear Implant, FM System)	Right Side	Left Side
Make and Model		
Serial Number		
Date of Purchase		
Date Warranty or Guarantee Expires		

Child's Amplification Information (continued)

Date Service Plan (if any) Expires		
Earmold Material and Style	/	/
Date the earmold was fit		
Type of Cord (if applicable)		
Accessories (if applicable)		

Amplification Contacts...	Name	Address	Phone Number
for repair			()
for programming			()
for batteries			()
for insurance			()

Special Concerns or Additional Information

Parent/Guardian Signature

Date

**Insert Your
Child's Most Recent Hearing Tests
into the Plastic Sheet Protector**

**Insert Your
Individualized Family Service Plan (IFSP)
into the Plastic Sheet Protector**

**Insert Your
Health Insurance Information and Records
into the Plastic Sheet Protector**

Notes:



Between Providers and You

To be used by parents and providers for questions,
treatment suggestions, progress notes, etc.

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