Parents:

Thank you for your time. Pages 1 and 2 will ask you about your child and yourself. Next, there are four sections that will ask for your feelings and experiences with professionals. Please answer truthfully and fill in/circle your answers. If you have two children with hearing loss, please fill out two separate forms.

Please mail your completed pages to:

Karen Aguilar, Coalition Director
CHOICES for Parents
PO Box 806045
Chicago, IL 60680-4121

CHOICES for Parents is a statewide coalition of parents and professionals ensuring that children with identified hearing loss and their families receive the necessary resources, advocacy, information, services and support. CHOICES for Parents is committed to providing unbiased information.

Children and Hearing Loss is a free resource manual that is filled with information about hearing loss, early intervention, technology, education, pediatricians and more. Produced by CHOICES for Parents, the resource is available in English and Spanish or on a CD.

To request your free copy of *Children and Hearing Loss*, or if you have any questions or would like more information about CHOICES for Parents, please contact Karen Aguilar at 866.733.8729 or e-mail info@choicesforparents.org.

Thank you again,

Karen Aguilar

This MVOS was adapted with permission from: Young, A.M., Gascon-Ramos, M., Campbell, M., and Bamford, J. (2009) The Design and Validation of a Parent-Report Questionnaire for Assessing the Characteristics and Quality of Early Intervention Over Time J. Deaf Stud. Deaf Educ. *14(4): 422-435.*

City: _____ Zip code: _____ Year child was born: _____ Was your child born in Illinois (please circle): Yes No

Did your child pass newborn hearing screening: Yes No

At what age was your child identified with a hearing loss? Years: _____Months: _____

Diagnostic Results: Unilateral (one ear) Bilateral (two ears)

Has your child been identified as having Auditory Neuropathy/Dys-synchrony: Yes No

Degree of Hearing Loss: Right Ear: Mild Moderate Moderate-Severe Severe Profound

Left Ear: Mild Moderate Moderate-Severe Severe Profound

Are you a: mother father grandparent guardian other _____

Is your child now or previously enrolled in intervention services (early intervention through the state or private)? Yes No

Did it begin by 6 months of age (please circle)? Yes No

Does/Did you child have an IFSP (Individual Family Service Plan) through your local Child and Family Connections (Illinois Early Intervention) office?

Yes No

Did your child receive services privately (through a private school or provider)? Yes No

At the time of this survey, what is your primary language used at home? English Spanish Polish Sign Language Other _____

At the time of this survey, what is the primary communication mode used in your home with your child with hearing loss:
Oral/Speech ASL Signed English Cued Speech Total Communication

Please circle any of the evaluations that your child has received to date: vision genetics speech and language
occupational evaluation physical evaluation developmental evaluation other: _____

Please circle any therapies that your child has had to date: speech and language occupational evaluation physical evaluation
developmental evaluation other: _____

Who **first** explained to you the different ways to communicate with your child? Developmental Therapist Developmental Therapist/Hearing
Service Coordinator another parent audiologist ENT Other Early Intervention provider: _____

1. What challenges did you experience related to getting your child's hearing test completed after leaving the hospital (check all that apply)

_____ My baby was not screened at the hospital
_____ Unsure of where to go after our baby failed the screening
_____ Screening test results were not shared with us
_____ Delay in appointment availability
_____ ABR test only available under sedation
_____ Missed appointments due to: _____
_____ Transportation problems
_____ Unable to afford the test
_____ Our baby had other medical/health problems
_____ Our baby had middle ear fluid
_____ We live far from the testing clinic
_____ Repeated testing was needed
_____ Other, please specify: _____

2. When you first found out that your child had a hearing loss, many concerns arose in the following weeks. Place an X next to the top 3 concerns you experienced

_____ Your child's medical needs
_____ Your family's finances
_____ Your child's success in school
_____ Your child's ability to make friends
_____ Your child's ability to communicate with the family
_____ Who would pay for your child's hearing aids
_____ Where your child would get speech and language therapy
_____ Other, please specify: _____

WHICH PROFESSIONALS WORK WITH YOU?

	Do you and your child receive services from:		Were you offered this service?		How much did working with this provider reduce your level of stress?*	How much did working with this provider improve your ability to communicate with your child?**	How much did working with this provider increase your comfort level with hearing loss?***
Pediatrician	Yes	No	Yes	No	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Developmental Therapist/Hearing	Yes	No	Yes	No	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Deaf Mentor	Yes	No	Yes	No	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Cochlear Implant Team Member	Yes	No	Yes	No	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

1 = Not at all/5 = Very much

*1 = Not at all (no impact on stress)
5 = Very Much (Greatly decreased stress)

**1 = Not at all (no ability to better communicate)
5 = Very Much (Greatly improved ability to communicate with your child)

***1 = Not at all (not more comfortable with hearing loss)
5 = Very Much (much more comfortable with hearing loss)

WHAT DO SERVICES PROVIDE YOU WITH?

	How important is this for you now?				How much have you received of this to date?				Are you currently satisfied with this? Not at all				Very much
Information about available services	Not Important	Somewhat Important	Important	Very Important	Nothing	Not Enough	Enough	Too Much	1	2	3	4	5
Information about how to communicate with my child who is deaf/has hearing loss	Not Important	Somewhat Important	Important	Very Important	Nothing	Not Enough	Enough	Too Much	1	2	3	4	5
Knowledge about how deaf children grow up	Not Important	Somewhat Important	Important	Very Important	Nothing	Not Enough	Enough	Too Much	1	2	3	4	5
Professionals help me to make my needs known and to fight for things necessary	Not Important	Somewhat Important	Important	Very Important	Nothing	Not Enough	Enough	Too Much	1	2	3	4	5
Coordination of all of the services, and professionals involved with my child and family	Not Important	Somewhat Important	Important	Very Important	Nothing	Not Enough	Enough	Too Much	1	2	3	4	5
Support to make decisions about my child who is deaf/with hearing loss and my family	Not Important	Somewhat Important	Important	Very Important	Nothing	Not Enough	Enough	Too Much	1	2	3	4	5
Confidence building in parenting a child who is deaf/with hearing loss	Not Important	Somewhat Important	Important	Very Important	Nothing	Not Enough	Enough	Too Much	1	2	3	4	5
Contact with other parents of deaf children/with hearing loss (parent-to-parent support)	Not Important	Somewhat Important	Important	Very Important	Nothing	Not Enough	Enough	Too Much	1	2	3	4	5

TO WHAT EXTENT ARE PROFESSIONAL SERVICES…

	Not at all				To a great extent	How important is this for you now?			
Trusting you as the expert.	1	2	3	4	5	Not Important	Somewhat Important	Important	Very Important
Taking into account your family's culture and lifestyle when working out support plans.	1	2	3	4	5	Not Important	Somewhat Important	Important	Very Important
Providing an optimistic view of the future.	1	2	3	4	5	Not Important	Somewhat Important	Important	Very Important

WHAT HAS BEEN THE RESULT OF SERVICES/SUPPORT?

Overall, how much have professional services made a difference for:

	Not at all				Very much	
Your child	1	2	3	4	5	
Yourself	1	2	3	4	5	
Other parent/guardian	1	2	3	4	5	N/A
Child's Siblings	1	2	3	4	5	N/A
Extended Family (Grandparents, aunts/uncles, etc.)	1	2	3	4	5	N/A

Has this difference been positive for:

Your child	Yes	No
Yourself	Yes	No
Other parent/guardian	Yes	No
Child's Siblings	Yes	No
Extended Family (Grandparents, aunts/uncles, etc.)	Yes	No

If enrolled in the Guide By Your Side program, who is your Parent Guide? _____

Please indicate areas for which you would like additional information. You will be asked in the final question to provide your contact information (if you wish to be contacted):

___ To receive a free copy of the "Children and Hearing Loss."
___ To be matched with a Guide By Your Side Parent Guide.
___ To be contacted by Illinois Hands and Voices to receive information about parent activities.
___ To volunteer with parent organizations or at the state level with the IL EHDI program.

□ Please contact me with additional information and resources for my family.

Name: _____

Address: _____

City, State, Zip: _____

Phone: (_____)_____ E-mail: _____