

REFERRAL TO: INFANT & EARLY CHILDHOOD MENTAL HEALTH SUPPORT

Date: Family Information Family Funding sources (please check all that apply): El	HS HS IS TB UPK
Child's Name: Date of Birth: Siblings/ages (If enrolled in PSD please list school and grade)	
Parent/Guardian Name(s): Home Address:	
Home Phone:MedicaidCHP+Private: Home Language:	
School & Staff Information: place check(s) beside those who provided referral information Family Mentor/ Specialist:School &Teacher:Other(specify):	
Parent/Guardian(s) have been told about EC Mental Health SupportYesNo	
Reason for Referral (check all that apply)	
Inappropriate behavior (specify):	Toileting skills concerns
Parents expressed interest in receiving counseling	Withdrawn, isolated, secretive behavior at home or school
Concerns about family (recent divorce, separation, etc)	Possible abuse concerns
Crisis in family	Post-Partum Depression
Death in family	Disruptive behavior at home
Disruptive behavior in class	Concerns about attachment/bonding
Parent reports depressed/anxious/overwhelmed	Concern that parent has inappropriate expectations
Specify Referral : Additional Information:	
Strategies that have been used thus far: specify	
redirection	classroom/behavioral observation
time out	consultation between teacher
discussion with parents	help with referral to outside agency
other classroom management techniques	other/specify:
family service provider/mentor contacted	
Primary need: call parent(s)	Collaborations & Referrals Other Professional(s) consulted? (list names if yes):
assessment	PSD: Community:
short term counseling for parent(s)	Referred parents to (specify):
provide parent(s) with information	

Teacher/Mentor/Staff Signature: _____