REFERRAL TO: EARLY CHILDHOOD MENTAL HEALTH SERVICES

Family Funding sources (please circle all that apply) **EHS HS CPP IS TB**

Child's Name: _____ Date of Birth: _____

Siblings/ages (If enrolled in PSD please list school and grade)

_____

_____

Date of Referral: _____

Parent's Name: _____

Home Address: _____

Home Phone: _____ Work Phone: _____ Can we call at work? ___ Best time to call: _____

Health Coverage: ___Medicaid ___CHP+ ___Private

Referred by:

Parent_____ Family Mentor_____ Classroom site_____

Other (please specified) _____

School Site_____ Teacher name_____ AM____ PM____

Family Mentor _____

Reasons for Referral (check all that apply and circle most important reason)

___Inappropriate behaviors
Specify: _____

___Parent(s) expressed interest in receiving counseling

___Concerns about family (recent divorce, separation) etc.

___Crisis in family

___Death in the family

___Disruptive behavior in classroom

___Parent seems depressed/anxious/ overwhelmed

___Toileting skills concerns

___withdrawn, isolated, secretive behavior at home or school

___Possible abuse concerns

___Post-Partum Depression

___Disruptive behavior at home

___Concerns about attachment/bonding

___Concern that parent has inappropriate expectations

Specify: _____

Additional Information: _____

Other Professional consulted: No ___Yes___ name: _____

Strategies that have been used thus far:

___redirection
___time out
___discussion with parents

specify: _____
_____

___other classroom management techniques
___family service provider/mentor contacted

referred parent(s) to: _____
other: _____

Primary need:

___call parent(s) ____
___observation
___evaluation
___short term counseling for parent(s)

____classroom observation/behavioral

___consultation between teacher and counselor
___help with referral to outside agency

___provide parent(s) with information on child management techniques

other/specify: _____
_____

Parents have consented to EC Mental Health Services___Yes ___No

Referral Signature: _____

Original copy: sent to Corinne Van Dyke,
Fullana Learning Center
Copies: Parent and Classroom file
Fax/email Copy: Corinne Van Dyke Support, 490-3134 or cvandyke@psdschools.org
Revised June 24, 2015