Community Colleges of Spokane

Spokane County Head Start/ECEAP/EHS

MENTAL HEALTH CONSULTANT INFORMATION

Child's name_____ Date ____/____/____

Birth date ____/____/____ Site _____ Room_____ Session_____

Parent's/guardian's name_____ Staff/teacher/FSC_____

CHILD REFERRAL

Who initiated referral?_____

With whom does the child live? Name_____ Relationship _____

How many people live in the home? Adults_____ Children_____

Any pertinent family background information (culture, language, health concerns, social services used, etc.)

_____

Classroom staff/parent have noted these areas (check all that apply):

- ❑ Withdrawn
- ❑ Over compliant
- ❑ Verbally aggressive
- ❑ Physically aggressive
- ❑ Destructive to property
- ❑ Doesn't respond to limits
- ❑ Atypical social interactions
- ❑ Atypical sexual language or information

PERMISSION IS GIVEN FOR THE FOLLOWING:

❑ Yes ❑ No Consultant's observation and interaction with enrolled child, and consultation with parent(s) and staff

❑ Yes ❑ No Review of child/family file

THE SERVICES WILL BE PROVIDED BY:_____

Consultant's name

As parent/guardian, I give permission for my child to receive the above mental health services.

Parent/guardian signature_____ Date_____

Staff member signature_____ Date_____

VALID FOR ONE YEAR FROM DATE OF SIGNING

To be completed by MHC after consultation

Child observations and/or recommendations for parents and staff:_____

_____

_____

_____

❑ Child observation and Individualized Positive Guidance Plan form completed.

❑ Recommend further screening/assessment

MHC signature_____ Date_____

Center Manager's initials_____

Center Manager review and initial
MHC completes consultation documentation

Copy—Mental Health Consultant Original—Child's File Copy—Center Manager (then forward to Mental Health Coordinator)