Community Colleges of Spokane

# Spokane County Head Start /ECEAP/EHS
# MENTAL HEALTH CONSULTANT DOCUMENTATION

Child's name _____ Parent's name _____

Date of MHC appointment ____/____/____ Site _____ Classroom _____ ☐ AM ☐ PM ☐ Full day

MHC met with _____

Session content _____

_____

_____

Impression _____

_____

_____

Plan _____

_____

Follow up appointment ____/____/____ Time _____

MHC made a referral to _____ Phone _____

MHC signature _____

Original – Child's file

Copy – Mental Health Consultant

Copy – Center Manager
(then forward to Mental Health Coordinator)