



Early Childhood Mental Health Consultation Program Request for ECMHC Services

Date _____ Case ID (assigned by consultant) _____

Child's Name _____ Date of Birth _____

What is the primary reason for your request? (Check the area that most closely matches your concerns.)

- Attachment** (ex. does not seek familiar adults for comfort, displays very little emotion or is emotionally dependent, wariness/on-guard, fearfulness, rejection or avoidance of touch)
- Self-regulation** (ex. tantrums, inconsolable "fussiness" or irritability, incessant crying, poor impulse control, inability to comfort/calm self, and limited coping skills with emotions/stress)
- Communication** (ex. limited or no communication (including non-verbal), lack of language that is considered developmentally appropriate)
- Aggression** (ex. any attempt or actual physical contact with another person in the form of hitting, kicking, biting, choking, pushing, poking, pulling hair, spitting, throwing things with directional intent)
- Interaction** (ex. withdrawn, difficulty playing, sharing or exchanging materials with others, difficulty taking turns, little interest in sights/sounds/touch)

Use this area to further explain your concerns.

Does the child have an IFSP or IEP? Yes No

List other agencies involved with this child: _____

Is the child at risk for expulsion from the program? Yes No

Have you discussed your concerns with the child's parent(s)? What is their understanding of the problem?

Facility Information

Facility Name: _____ MPDCI #: _____

Director Name: _____ Facility Type: Center Family Group

Address: _____

Phone: _____ Fax: _____ E-mail: _____

County: _____

STAR Level: Start w/STARS STAR 1 STAR 2 STAR 3 STAR 4 accredited

Region: Northwest Southwest Central South Central Northeast Southeast



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Classroom Information for referred child

1. Teacher Name: _____

Education Level: HS CDA AA BA/BS Masters Non-related degree

2. Teacher Name: _____

Education Level: HS CDA AA BA/BS Masters Non-related degree

Classroom Name: _____ Children in classroom: _____ Age range in classroom: _____

Facility Director Signature _____ Date _____

To be completed by classroom staff:

Have you completed a screening for this child? No Yes Please list tool/results: _____

What do you perceive is the primary reason for the child's behavior? (pick one)

- Needs attention
- Does not like to do what he/she is told
- Always needs to get his/hew own way
- Wants to help others
- Doesn't know how to follow rules

Provide additional reasons here:

Please list strategies you have tried, as well as the results:

- Ignore behavior
- Take away toys/snack
- Redirect
- Give extra attention
- Assign a time out

Explain results of strategies:



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Please rate your knowledge in the following areas:

Knowledge Area	Excellent	Good	Fair	None
Understanding possible reasons for challenging behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding the use of screening tools to identify developmental concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Availability of community resources to assist a child and his/her family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How to discuss concerns with a child's family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of practices to build relationships with children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding of methods to address challenging behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to meet the social-emotional needs of children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Return this form to: _____