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, incombolable “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 withdrawn, difficulty playing, sharing or exchanging materials with others, difficulty taking turns, little interest in sights/sounds/touch)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 ☐ SouthCentral ☐ 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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To be completed by referred child’s teacher.

Please rate your knowledge in the following areas:

<table>
<thead>
<tr>
<th>Knowledge Area</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding possible reasons for challenging behavior</td>
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<tr>
<td>Understanding the use of screening tools to identify developmental concerns</td>
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<td>Availability of community resources to assist a child and his/her family</td>
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<td>How to discuss concerns with a child’s family</td>
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<td>Use of practices to build relationships with children</td>
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<tr>
<td>Understanding of methods to address challenging behaviors</td>
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<td>Ability to meet the social-emotional needs of children</td>
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What specific help are you hoping the ECMH Consultant will provide?

Describe your previous experience/s working with a consultant?

Name three strengths in your role as an early care educator?

Referred Child’s Teacher’s Signature ___________________________ Date ___________________________

Return this form to: Diane Milia, fax 610-432-5700 or scan to dmilia@cscinc.org