Pennsylvania Infant/Early Childhood Mental Health Consultation Request for IECMHC Services Form

*Return to Completed Form to PAIECMH@pakeys.org or fax 717-213-3749

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 independent, 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 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 withdrawn, difficulty playing, sharing or exchanging materials with others, difficulty take turns; little interest in sights/sounds/touch)

Use this area to further explain your concerns:

Child Information:

Gender: □ Male □ Female

Race/Ethnicity:

□ American Indian/Alaskan Native (not Hispanic) □ Asian (not Hispanic)
□ Black or African American (not Hispanic) □ Hispanic (any race)
□ White (not Hispanic) □ Multi-Racial (not Hispanic)
□ Native Hawaiian or other Pacific Islander (not Hispanic) □ Unknown

Does this child receive Child Care Works Subsidy? □ yes □ no

Does the child have an IFSP or IEP? □ yes □ no

What other agencies are involved with this child/family? □ Child Welfare □ Child Mental Health □ EI 0-3
□ EI 3-5 □ Case Management Services □ Head Start □ Pre-K Counts □ Home Visiting

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

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Facility Information

Facility Name:_____MPI #_____

Director Name**:** _____ Facility Type: ☐ Center ☐ Family ☐ Group

Address: _____

Phone_____Fax:_____ Email:_____

County:_____

STAR Level: ☐ STAR 1 ☐ STAR 2 ☐ STAR 3 ☐ STAR 4 ☐ Accredited

My program is in the following Early Learning Resource Center (ELRC):

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19		

Facility Director Signature: _____ **Date:** _____

Classroom Information (for referred child):

1. Teacher Name:_____PD Registry ID #: _____

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

2. Teacher Name:_____PD Registry ID #_____

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

Classroom Name:_____#Children in classroom:_____Age Range in Classroom:_____

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 child's behavior? (please pick one)

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

Provide additional reasons here:

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Please list strategies you have tried; and the results.

□ Ignore behavior
□ Take away toys/snack
□ Redirect
□ Give extra attention
□ Time Out

Describe results of strategies:

The statements below describe how some teachers might feel about a child in their classroom. Please indicate how strongly you agree with each statement based on the child you are referring for ECMHC. Remember there are no right or wrong answers, so please give your honest opinion and feelings. (Gilliam & Reyes, 2016)

	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree
This child's classroom behaviors interfere with my ability to teach effectively.	1	2	3	4	5
This child's classroom behaviors interfere with my ability to maintain control of the class.	1	2	3	4	5
This child's classroom behaviors interfere with other children's opportunity to learn.	1	2	3	4	5
This child's classroom behaviors may result in someone getting hurt or property being damaged.	1	2	3	4	5
This child might do something for which I would be held responsible, reflecting poorly upon my teaching skills.	1	2	3	4	5
Other parents complain about this child's classroom behaviors.	1	2	3	4	5
This child's classroom behaviors are not likely to improve significantly.	1	2	3	4	5
There is little that I or anyone else can do to significantly improve this child's behavior.	1	2	3	4	5
This child's parents will not be much help in improving this child's behavior.	1	2	3	4	5
My job as a teacher would be easier if this child were not in my classroom.	1	2	3	4	5
My job is more stressful because of this child's behaviors.	1	2	3	4	5
Some mornings I find myself hoping that this child will be absent from my classroom.	1	2	3	4	5

Infant/Early Childhood Mental Health Consultation Program
Parent/Facility Agreement

Child: _____ Date of Birth: _____

Parent/Guardian: _____

Address: _____ Zip Code: _____

Phone: _____ E-mail address: _____

- I authorize the Early Childhood Mental Health Project to provide, perform or participate within the following services. These services are offered at no cost. I give my permission for the Early Childhood Mental Health Consultant to:
  - Observe my child in his/her classroom setting and consult with the staff at the Early Learning Facility.
  - Provide consultation services to myself and my child's teachers within the Early Learning Facility.
  - Conduct a developmental screen, using a standardized tool, across all domains of my child's development.
- I understand that the Early Childhood Mental Health Consultant may provide me with information about child-related issues and resources within my community that could be helpful.
- I agree to provide any necessary information about my child and understand that this information will be kept confidential.
- I agree that the IECMH Program may collect a variety of data about me and my child(ren) and store these data on a secure database. Only professional staff authorized by PA Key will have access to these data. All data will be kept confidential, and aggregated data may be used in evaluation or research reports to help improve the program.
- I understand that I will be invited to participate in team meetings and action plan development. This participation is voluntary, and any party may discontinue participation at any time, preferably by notifying the other party in writing.

Parent/Guardian Signature _____ Date _____

Early Learning Facility _____

Facility Address _____

Contact: _____ Phone: _____

E-mail address: _____

I authorize the Early Childhood Mental Health Consultation Project to provide, perform or participate within the following services.

- I will facilitate the Early Childhood Mental Health Consultant's classroom visits, observations, review documentation and contact with the child's parent guardian.
- I agree to participate in team meetings, assist with collecting documentation and facilitate the implementation of recommendations to the consultant.
- I agree to keep all information review, shared and received confidential.

Facility director signature _____ Date _____

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FOR ADMINISTRATIVE USE ONLY

I revoke authorization related to the Early Childhood Mental Health Project. I understand this means my child will not receive screening or referrals to community-based services facilitated by ECMHC, and that the teachers working with my child will not receive information related to how best to work with my child in the classroom setting.

Parent/Guardian Signature _____ Date _____