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 withdrawn, difficulty playing, sharing or exchanging materials with others, difficulty taking turns, little interest in sights/sounds/touch)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	☐	☐	☐	☐
Understanding the use of screening tools to identify developmental concerns	☐	☐	☐	☐
Availability of community resources to assist a child and his/her family	☐	☐	☐	☐
How to discuss concerns with a child's family	☐	☐	☐	☐
Use of practices to build relationships with children	☐	☐	☐	☐
Understanding of methods to address challenging behaviors	☐	☐	☐	☐
Ability to meet the social-emotional needs of children	☐	☐	☐	☐

Return this form to: fax to 267-765-2397; email to smcclaffer@phmc.org

mail to SERK at PHMC, LM 500, Lower Mezzanine West Tower, 1500 Market Street, Philadelphia, 19102