



Pennsylvania Early Childhood Mental Health Consultation Request for ECMHC Services Form

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 withdrawn, difficulty playing, sharing or exchanging materials with others, difficulty take turns; little interest in sights/sounds/touch)

Use this area to further explain your concerns:

Child Information:

Gender: Male Female

Race/Ethnicity:

- | | |
|---|--|
| <input type="checkbox"/> American Indian/Alaskan Native (not Hispanic) | <input type="checkbox"/> Asian (not Hispanic) |
| <input type="checkbox"/> Black or African American (not Hispanic) | <input type="checkbox"/> Hispanic (any race) |
| <input type="checkbox"/> White (not Hispanic) | <input type="checkbox"/> Multi-Racial (not Hispanic) |
| <input type="checkbox"/> Native Hawaiian or other Pacific Islander (not Hispanic) | <input type="checkbox"/> 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

Case Management Services EI 0-3 EI 3-5 Head Start Pre-K Counts

Is the child at great risk for expulsion from the program? yes no

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

Region: Northwest Southwest Mid-State Northeast Southeast

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: _____

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 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

Explain results of strategies:

13. Please rate your knowledge level in the following areas.

	Excellent	Good	Fair	None
Understanding possible reasons for challenging behavior	1	2	3	0
Understanding the use of screening tools to identify developmental concerns	1	2	3	0
Availability of community recourses to assist a child and his/her family	1	2	3	0
How to discuss concerns with a child's family	1	2	3	0
Use of practices to build relationships with children	1	2	3	0
Understanding of methods to address challenging behaviors	1	2	3	0
Ability to meet the socio-emotional needs of children	1	2	3	0

Return this form to your Regional ECMHC Program:

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Southeast Regional Key
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