m·s·p·c·c
A DIVISION OF ELIOT

Early Childhood Mental Health Consultation

Individual Child Referral Form **Referral Date: _____ / _____ / _____**

Please email referral form to MHCintake@eliotchs.org or fax to 857-288-4612

Child Information

Child's Name: _____ DOB:_____ Gender: M ☐ F ☐

Address: _____

Parent/Guardian Name: _____ Phone Number: _____

Child living with: ☐ Parent ☐ Other Family Member ☐ Foster Parent ☐ Other _____

Preferred Language of Parent/Guardian: _____ Child's Race/Ethnicity:_____

Type of Child Care Slot: ☐ Voucher ☐ DCF Supportive ☐ Private ☐ Other

Other services child is receiving/has received: ☐ Early Intervention ☐ Individual/Family Therapy ☐ IFSP

☐ Special Education Evaluation ☐ IEP ☐ 504 ☐ DCF ☐ FS&T/ICC/TM ☐ Other: _____

Center Information

Program Name: _____ EEC Program ID: _____

Address: _____ Phone: _____

Director Name: _____ Email: _____

Classroom Name: _____ Classroom Type: _____

Teacher's Name(s):_____

Reason for Referral

Please provide a brief narrative including challenging behaviors observed in classroom. Please be as specific as possible!:

_____

_____

_____

☐ Aggressive behavior - towards: ☐ Children ☐ Adults ☐ Property ☐ Self
☐ Attention difficulties ☐ Extreme tantrums / lack of emotional control ☐ Oppositional behavior
☐ Over activity/Impulsivity ☐ Withdrawn/overly shy behavior ☐ Developmental concerns
☐ Concerns with social skills/peer relations ☐ Trauma ☐ Sexualized behavior ☐ Other: _____

Please provide a brief narrative of intervention techniques classroom has previously utilized, and child's response:

_____

_____

Please provide three goals program staff hope to achieve through consultation services. As consultation services are intended as support for staff, goals will be related to what teachers seek to accomplish through consultation and/or coaching, rather than goals related to specific child behavior. Please be as specific as possible! Thank you

1. _____
2. _____
3._____

Eliot Community Human Services
Early Childhood Mental Health Consultation

Consent for Services

Child's Name: _____ **DOB**: _____

Name of Program: _____

Director: _____ Educator/Provider: _____

Program Address: _____

Program Telephone #: _____ Fax #: _____ Email: _____

Parent/Guardian(s): _____

Address: _____

Preferred Telephone #(s): _____

E-mail (if agreeable to also being contacted this way): _____

Please check the boxes if consent is given; all boxes must be checked to be considered complete.

☐ I give my permission for the above mentioned Child care Agency to exchange information about my child with MSPCC's Mental Health Consultation Team.

☐ I give my permission for MSPCC's Mental Health Consultation Team to provide some or all of the following services:

1. Consultation with the child care program's staff regarding behavioral and/or social - emotional issues.
2. Consultation with the parent or guardian.
3. Observation of my child in the school/child care setting.
4. Social-emotional, behavioral screening/assessment.
5. Development of an individual behavior support plan.
6. Recommendations for ongoing services.

☐ I understand that someone from the Mental Health Consultation Team will be contacting me and keeping me updated on all of the services that are recommended and/or provided.

_____ _____

Parent/Guardian Signature Date

Fax Referral to Program Director at 857-288-4612 or email to mhcintake@eliotchs.org

Early Childhood Mental Health Consultation
Consent for Video Observation and Coaching Services

Child's Name: _____ **DOB:** _____

By signing this form, I authorize MSPCC/Eliot Community Human Services to provide ongoing virtual observation and consultation services for my child as they collaborate with child-care staff regarding the development of social-emotional skills in young children. Services will include classroom observation and consultation regarding specific strategies to promote these skills.

Due to the current Department of Early Education and Care (EEC) Health and Safety Guidelines which prohibits outside visitors, observations will be provided using a virtual platform. Virtual observations will **NOT** be recorded. This virtual observation will only be accessible to assigned Early Childhood Mental Health Consultation staff and program director.

I understand that I have the right to withhold my consent to the use of virtual observation in the course of my child's consultation service at any time, without affecting my child's right to future consultation services. I understand that by signing this form I may revoke my consent in writing at any time. As long as this consent is in force (has not been revoked) MSPCC/Eliot Community Human Services may provide services to my child via virtual platform without the need for me to sign another consent form.

Please contact Early Childhood Mental Health Consultation program director, Jayna Doherty, with additional questions at 508-688-5408 or jdoherty@eliotchs.org.

Parent Name Print: _____

Parent Signature: _____

Date: _____

Dear Parent/Guardian,

The Massachusetts Department of Early Education and Care (EEC), Early Childhood Mental Health Consultants, (ECMHC) and _____(the "Program")

are working together to prevent, identify, and reduce the impact of behavioral and emotional distress upon young children through the use of on-site early childhood mental health consultation and mentoring. In addition, this work includes training and coaching in order to strengthen program leaders, and to strengthen the capacities of administrators and educators capacities to reflect, problem solve, and be effective in their roles to identify risks and prevent or reduce social-emotional and behavioral concerns that might arise.

As part of a broader comprehensive statewide system of mental health supports for children and families, EEC aims to provide a statewide system of ECMHC services. The consultation services funded through this grant are designed to provide support and guidance to programs, educators, and families to address the developmental, social and emotional, and behavioral challenges of infants and young children that will support healthy development, reduce the suspension and expulsion rate in early education and care settings, and promote school success.

The Consent Form below requests your permission to share information, which is not considered personally identifiable information, to EEC in an aggregate format in order for EEC to understand the effect of such services and to provide information on the much needed services for social emotional services supports for children and families.

The Consent Form also requests your permission to share the data with other agencies of the Commonwealth of Massachusetts. The data to be shared will not be connected to a child, classroom, or program. **Please note that we will combine (aggregate) the data of many children and will not identify any specific individual child.** All personally identifiable linked to a specific child **will be confidential to ensure the privacy of your child and you.** If you do not wish to have any information shared, you may decline this option. Declining this such option will have no impact upon child's early care and education program's ability able to request support through the Early Childhood Mental Health Consultation, and no information will be shared.

If you choose to participate in the Early Childhood Mental Consultation Supports through your early care and education program, please complete the Consent Form below. Thank you!

Early Childhood Mental Health Consultation (ECMHC) Family Consent Form

Please read the text below and check the box to indicate whether you permit your child to participate in the Early Childhood Mental Health Consultation Supports:

☐ By checking this box, I acknowledge that I have read the information provided by the Department of Early Education and Care (EEC) about the Early Childhood Mental Health Consultation Supports and:

- **I agree** to have non-identifiable information entered into the ECMHC reporting database, and
- **I agree** to have non-identifiable information shared with the Commonwealth of Massachusetts, and any of its designated agents or assigns, for the purposes of state-wide data collection that reviews only at aggregated data to determine need for future trainings for early childhood professionals, and policies.

☐ By checking this box, I acknowledge that I have read the information provided by the Department of Early Education and Care (EEC) about the Early Childhood Mental Health Consultation Supports and:

- **I do agree** to have my child's non-identifiable information entered into the ECMHC reporting database, and
- **I do not agree** to have my child's non-identifiable information shared with the Commonwealth of Massachusetts and any of its designated agents or assigns.

☐ By checking this box, I acknowledge that I have read the information provided by EEC about the Early Childhood Mental Health Services, and I decline to have my child(s) data entered in the ECMHC database.

_____ _____

Name of Parent or Guardian Date

_____

Signature of Parent or Guardian