Arrowhead Head Start

CHILD REFERRAL FORM

(revised May, 2021)

- Save As…
- Electronic naming convention: CRF – SiteName - ChildFirstName ChildLastName – Date of Referral
- Email completed form to: Disability and Mental Health Manager **AND** Data Entry Specialist

*Check **ALL** referrals types you would like to request for this child **– MULTIPLE referrals can be made using one form.***
*For **ALL** referrals checked, complete the corresponding section(s) below*

☐ ECSE-HMG

☐ Social-Emotional Observation

☐ Mental Health Services by Outside Agency (ie: ADAPT/CTSS)

HS Staff Name:_____ Date of Referral:_____

***Complete the following section for ALL referrals* –**

In order to fully complete our community partner referral requirements, ALL items are required.

Child Name:_____ CPID #:_____ HS Site:_____

Date of Birth:_____ Child's Age:_____ Gender: ☐ Male ☐ Female

Child Resides With: ☐ Parent/Guardian ☐ Other Family Member ☐ Foster Parents ☐ Other_____

Parent/Guardian(s) Name (First, Last): _____

Address:_____ City:_____ Zip:_____

Primary Phone: _____ Secondary/Contact Phone:_____

Interpreter needed? ☐ Yes ☐ No

If yes, interpreter for: ☐ Child ☐ Parent/Guardian ☐ Both Interpreter Type?_____
(ex: Sign Language, Spanish, etc.)

Developmental Screening Score:_____

Social-Emotional Screening Score:_____

Complete this section IF you checked ECSE-HMG:

- **Consent for Release of Information is required.** ☐ Consent Signed and returned to Virginia Office?

Parent Response to Referral: ☐ Consented ☐ Refused If refused, reason: _____

Reason for referral:

☐ Known medical diagnosis:

☐ Suspected disability (check all areas of concern):

☐ Cognitive ☐ Social/Emotional/Behavior ☐ Speech/Language ☐ Gross Motor

☐ Fine Motor ☐ Adaptive/Self Help ☐ Other _____

Please describe in detail the reason, situations, behaviors you have observed relating to this **ECSE-HMG** referral.

Complete this section IF you checked Social-Emotional Observation:

- **No Consent for Release of Information required.**
- **Strength and Difficulties Questionnaire (SDQ) is required.**
- **Email completed SDQ with this referral form.**

Parent Response to Referral: ☐ Consented ☐ Refused If refused, reason:_____

☐ This is a parent request for Social-Emotional Observation

Behaviors observed:

☐ Physical Aggression ☐ Disruption/Tantrums ☐ Running Away/Leaving Designated Area
☐ Verbal Aggression/Inappropriate Language ☐ Noncompliance/Not Following Directions
☐ Other

Please describe in detail the reason, situations, behaviors related to this **SOCIAL-EMOTIONAL OBSERVATION** referral, include number of Behavior Incident Reports (BIR) you have completed at the site.

Complete this section only IF you checked Mental Health Services by Outside Agency (ie: ADAPT/CTSS):

- **Strength and Difficulties Questionnaire (SDQ) is required. Email completed SDQ with this referral form.**
- **Consent for Release of Information is required.** ☐ Consent Signed and returned to Virginia Office?

Parent Response to Referral: ☐ Consented ☐ Refused If refused, reason: _____

☐ This is a parent request for a MH Outside Agency referral

Referral/Outside Service Requested:

☐ ADAPT/CTSS ☐ Other _____

Checked the preferred referral agency:

☐ Range Mental Health Center (RMHC) – available to northern tier classrooms
☐ Nystrom and Associates – available to northern and southern tier classrooms
☐ Human Development Center (HDC) – available to southern tier classrooms
☐ Accend Services – available to southern tier classrooms

Please describe in detail the reason, situations, behaviors related to this **MENTAL HEALTH SERVICES BY OUTSIDE AGENCY** referral.