Denver Health Early Childhood Mental Health Consultation

Request for Child and Family - Focused Consultation: Parent Acknowledgment Form

Early childhood is a time when children learn social and emotional skills that have life-long benefits, like learning to make friends, take turns with peers, and manage emotions. **Early Childhood Mental Health (ECMH) Consultants** work directly with the **adults** caring for children to build their capacity and skills to strengthen and support the healthy social and emotional development of children. **The best outcomes are reached when consultants and the adults they are working with form strong, trusting relationships.**

[Child's name] _____________________________was referred for **Early Childhood Mental Health Consultation (ECMHC)** to support them and enrich their experiences at home and in the classroom (when applicable). Consultation is voluntary and free of charge. Our services focus on your child's strengths, and we will not label or diagnose your child. If you choose to consent by signing this form, the consultant can proceed with the next steps of the process.

Your participation is very important; we cannot do this work without you. When applicable, this service also includes talking with your child's teacher and joining your child's classroom to observe them, the classroom, and the teacher. This allows the consultant to learn more about your child without disrupting their day. The consultant will also request that you and the teacher complete a questionnaire called the Devereux Early Childhood Assessment (DECA-C), which highlights both your child's strengths as well as possible areas for growth. The DECA-C will become part of a plan for how to best support your child. This plan will be created with you and other important adults in your child's life, such as their teacher or other caregivers. Based on the needs of your child, your individual preferences, and the consultant's availability, tele-consultation (i.e., virtual) or in-person consultation will be used to deliver services.

Services may include:

- Observation/feedback of adult(s) interactions with your child in different settings (e.g., classroom, playground, etc.)
- Education about typical child growth and developmental expectations
- Sharing strategies that help support your child's growth and development
- Discussion of ways to support your child during times of stress
- Engaging in conversations about your experiences as this child's caregiver
- Links to helpful resources and services

Parent/Caregiver Name: ____

❑ I will participate in these services by attending in-person, virtual and/or phone meetings at the frequency the consultant and I agree upon

❑ I consent to consultation services, but do not wish to participate ***(I understand that I am a very important part of the process and by not participating, my child's progress may be limited)***

Preferred days/times to connect with your consultant: ____

Phone number: ______________________________**Parent Email:** ____

Parent/Caregiver Signature: ____**Date:** ______________________

Throughout this process, you will be asked for basic information about you and your child, such as their date of birth, race/ethnicity, etc. What you share is confidential and will not be available to the public. The Colorado Department of Early Childhood (CDEC), Denver Great Kids Head Start (DGKHS) and Denver Health Early Childhood Mental Health Consultation (ECMHC) program will have access to this data for the purposes of overall program improvement, to help support the child, and to potentially refer the child to other high-quality early childhood programs, services, or resources offered through the CDEC. Any reporting that is required for the program will not include you or your child's name or other identifying information.

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Note: This page to be Completed by the Referring ECE Center Staff

Referral initiated by:

Name:____ Role:____

Email: ____

Child & Family Information:

Name of Child: ____ Date of Birth: ___________________________

Is there a custody agreement? ☐Yes ☐No If Yes, who has medical decision making? ________________________________

Education decision making? ____ Can you provide a copy? ☐ Yes ☐ No

Does the child have an IEP or IFSP: ☐ Yes ☐ No

Child's Race/Ethnicity **(Please circle):**

White, Black, Hispanic, Asian/Pacific Islander/Native Hawaiian, Middle Eastern/North African,
Native American/Alaska Native, Two or More Races, Prefer not to disclose

Address: ____

Child's Gender **(select one):** Male / Female / Transgender / Other: __________________________

Primary Language of child: ____

Name of Caregiver/Parent: ____

Caregiver (Parent/Guardian) Race/Ethnicity **(Please circle):**

White, Black, Hispanic, Asian/Pacific Islander/Native Hawaiian, Middle Eastern/North African,
Native American/Alaska Native, Two or More Races, Prefer not to disclose

Primary Language of parent/caregiver: _________________________________

Caregiver Telephone number: __________________________ E-mail: ____

Center/School: ____________________________________ Classroom: ____________________________________

Reason for referring this child for mental health consultation (as noted by the referring party):

- ❑ Biting
- ❑ Easily frustrated
- ❑ Dangerous play
- ❑ Doesn't Seem to Listen
- ❑ Sad/Depressed
- ❑ Does Not Communicate
- ❑ Doesn't Socialize w/ Peers
- ❑ History of Trauma /Adversity
- ❑ Withdrawn
- ❑ Aggressive behavior
- ❑ Play not age appropriate
- ❑ Walks Out of Classroom
- ❑ Separation Anxiety
- ❑ Doesn't Socialize w/ Adults
- ❑ Home/Family Stress
- ❑ Strained Provider-Family Relationship
- ❑ Screaming/Crying
- ❑ Anxious/Shy
- ❑ Challenges to Parenting
- ❑ Hard Time with Changes
- ❑ Developmental Delay
- ❑ Disrupts Classroom
- ❑ Recent Loss/Grief
- ❑ Other:_______________

Concerns are primarily at (circle one): Home School Both

Staff Signature: ____**Date:** ______________________________

(*Completed referral packet must include* ***signed*** *Parent Acknowledgment form; DECA-C completed by both teacher and caregiver*)

(Internal use only) Date Referral Packet Returned to Consultant: ________________________

DENVER HEALTH est. 1860 FOR LIFE'S JOURNEY

DENVER GREAT KIDS HEAD START

COLORADO Department of Early Childhood