South Carolina Association of Community Action Partnerships Early Head Start Child Care Partnerships

Mental Health/Disabilities Referral Form

This is for any individual who observes a concerning behavior in regard to one's mental or social emotional health, as well as any concerns in regard to a disability.

Center Name:

Please choose which best describes your role:

Teacher Parent Director Teacher Mentor Family Advocate EHS Staff

Name of Child or Family:

Name of Referrer:

Date:

Time:

am pm

Contact Number (Optional):

1. Does the child present areas of concern with social emotional regulation (e.g. temper tantrums, aggression towards peers, biting, prolonged crying)?

Yes No

2. Does the child show concerning behaviors that one would attribute to a disability (e.g. hand flapping, fixation with objects, prolonged dissociative staring)?

Yes No

3. Does the child have a previously diagnosed disability?

○ Yes ○ No ○ Unknown

4. Have you witnessed the following signs and symptoms? (Check all that apply)

☐ Frequent temper tantrums ☐ Inability to be comforted/soothed ☐ Physical aggression
☐ Biting ☐ Distress when dropped off ☐ Lack of social interaction ☐ Delay in speech
☐ Delay in reaching milestones ☐ None of the above ☐ Other

5. How often do you observe the behaviors? (If applicable)

☐ Rarely ☐ Once or Twice each month ☐ Once per week ☐ A few times per week
☐ Daily ☐ Multiple times per day ☐ Always

6. If this referral is not for a child, their parent, or family, but instead for a staff member please note their position here

☐ Teacher ☐ Teacher Mentor ☐ Family Advocate ☐ Director ☐ EHS Staff
☐ Other

Additional comments or observations

Please complete this form and it will be forwarded to Kyra Mathis, LMSW, Early Head Start's Mental Health Disabilities Specialist

South Carolina Association of Community Action Partnerships Early Head Start Child Care Partnerships 2711 Middleburg Drive Suite 208 Columbia, SC 29204 | Phone: 803-401-5490 | www.scacap.org