Send completed form to the ECMH Coordinator at (fax) 216.432.5037. Please call at (216) 881-4291 with questions or for more information.

Early Childhood Mental Health Request for Services-Cuyahoga County (children ages 0-6)

Today's Date:________________________________
Child's Name:________________________________ Child's Age : Years ________ Months __________
Child's Sex: ☐ Female ☐ Male
Child Lives with: (name)____ ______________
☐ parent ☐ foster parent ☐ kinship caregiver ☐ other______________

Contact Information:
Phone Number____________________________________ Alt.Phone________________________________
Address____City_____________________ Zip_______________
Family Availability: ____
Reason for Referral: ☐ sleeping/eating/soothing concerns ☐ problems with attention/focus
☐ aggressive behaviors ☐ bonding/attachment concerns ☐ sexualized behaviors
☐ sad or anxious behaviors ☐ challenging behaviors in classroom/daycare setting ☐ abuse/trauma
☐ other (*Please provide known details):* ____
____
____
____
____
Service Preference: ☐ Consultation ☐ Treatment ☐ Other_________________________
Referral Type: ☐ Routine ☐ Urgent ☐ Emergency
Name/title of person making referral____
Phone_____________________________________E-mail ____

To be Completed by Parent/Legal Guardian:
By signing below, I consent for the above information to be shared with one or more community agency/service for the purpose of facilitating a referral for Early Childhood Mental Health Services or for accompanying resources to help my family.

________________________ ____________________________ ______________________
Printed Name Signature Date

Please Note: Parent or Guardian signature must be obtained to process referral.

Referral Outcome/Coordinator Notes:

FOR OFFICE USE
REFERRED FOR: ☐ Treatment ☐ Consult ☐ Other Agency: ACC/AWC/BB/CRCC/DCFS/GSO/PEP/_______
Date: