Send completed form to the ECMH Coordinator at (Fax) 216-432-5037 or Mail to: ECMHReferrals@jfs.ohio.gov
Please call (216) 698-3553 with questions or for more information.

Infant and Early Childhood Mental Health Request for Services -- Cuyahoga County

Children Ages 0 to 6

Today's Date: _____ Child's Age: *Years* _____ *Months* _____

Child's Name: _____ Child's Sex: _____

Child lives with (Name) _____ Relationship: _____

Person with Custody: _____ Child's Soc. Security # _____

Medicaid # _____ Child's Birth Date: _____

CONTACT INFORMATION:

Phone # _____ Ext: _____ Alternate Phone # _____ Ext. _____

Address: _____ City: _____ Zip: _____

Family Availability: _____

REASON FOR REFERRAL: (Check all that apply)

- ☐ Sleeping/Eating/Soothing concerns
- ☐ Sad or anxious behaviors
- ☐ Abuse / Trauma
- ☐ Recent or at Risk for Disruption
- ☐ Problems with Attention/Focus
- ☐ Attachment / Bonding Concerns
- ☐ Challenging Behav. in Classroom/Daycare
- ☐ Regression / Loss of Skills
- ☐ Aggressive Behaviors
- ☐ Suspected Sexual Abuse/Concerns
- ☐ Withdrawn / Unresponsive
- ☐ Loss of Caregiver

Other _____

REFERRAL TYPE: _____

Name/Title of Person Providing Referral**:** _____

Phone # _____ E-mail _____

To be Completed by Parent or 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** **Emergency Response** **Other**

Agency: **ACC AWC BB CRCC DCFS GSO PEP CENTERS MT** _____