Head Start Mental Health Referral and Record of Follow-up Services

Unit: _____

Child Name: _____

Birth Date: _____

Parent/Guardian: _____

Address: _____

Phone #: _____ **E-mail:** _____

Referred by: _____ **Date:** _____

Reason for referral: _____

Dates of Documentation on Behavior log from _____**to**_____

Permission of Parent/Guardian for referral and release of information:

_____ **Date:** _____

Please copy this referral form and send:

One to the Central Office Attention to Mental Health Coordinator

One to Area Manager

For Mental Health Coordinator Use Only

Date of Referral: _____

Referral Agency: _____

Date Services Began: _____