Mental Health Screening

(Cover page - please attach original or copy of screening)

Child Name: ________________________________ **Unit:** _________________

Date of Screening/Assessment: ___/___/___

Provider Setting:
☐ Home ☐ Doctor/Clinic ☐ Other
☐ School Center ☐ Employment ☐ Sp/Ed Preschool

Completed by:
☐ Head Start Staff Staff Name: _____________________________________
☐ Other Agency Agency/Name: ____________________________________
☐ Parent/Guardian

Type of Assessment: X Screening ☐ Assessment

Instrument used: ASQ:SE **Language used:** English

Source(s) of Information:
☐ Observation ☐ Other Family Member ☐ Teacher ☐ Other: Specify _______________
☐ Parent/Guardian ☐ Home Visitor ☐ Child ☐ Other: Specify ________________

Result of Staff Review: ☐ No Problem ☐ Reassess ☐ Refer to Develop. Assessment Form

Domain	Score	Result	Needs Treatment/ Follow up	Comments*
Overall		☐ Concern (Fail) ☐ No Concern (Pass) ☐ Re-test	☐ Yes ☐ No	
*Referral/Follow up was made : ☐ Yes ☐ No				

- ***If referral was made, please attach a copy of the Head Start Treatment and referral record.***

MH Professional consulted with program staff about the child's behavior/mental health: ☐
a. MH Professional provided 3 or more consultations with program staff: ☐

MH Professional consulted with parent(s)/guardian(s) about the child's behavior/mental health ☐
a. MH Professional provided 3 or more consultations with parent/guardian: ☐

MH Professional provided an individual mental health assessment: ☐

MH Professional facilitated a referral for mental health services: ☐