

KidConnections
Initial Mental Health Assessment-
Assessment for Intervention Report
 (Toddler/Pre-School 25 months and older)

Child's Name _____ Parent/Caregiver Name: _____
 Birthday: ____ / ____ / ____ Age: _____
 Date of the assessment: ____ / ____ / ____ Unicare #: _____

Referral source:

<input type="checkbox"/> Family Court	<input type="checkbox"/> Family Wellness Court	<input type="checkbox"/> DDTC	<input type="checkbox"/> DR	<input type="checkbox"/> Path 1	<input type="checkbox"/> Path 2
<input type="checkbox"/> HRIF	<input type="checkbox"/> IND	<input type="checkbox"/> Kidscope	<input type="checkbox"/> SARC	<input type="checkbox"/> Pediatrician	
<input type="checkbox"/> Early Start	<input type="checkbox"/> Head Start	<input type="checkbox"/> F5 Parent Workshop	<input type="checkbox"/> F5 FRC	<input type="checkbox"/> Head Start Non-PoP	

Referring Person:	Referrer Agency/School:	Referrer Phone:	Referrer E-Mail:
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Identifying Information and History:

Client description, referral reason, referral source
 Family Members, Significant Individuals

Cultural Factors and Linguistic Considerations:

(e.g. ethnicity, immigration, language, religion, sexual orientation, etc; **ways cultural factors may influence child's needs and treatment**)

Presenting Concerns: (mental health/ behavioral issues, developmental issues, current symptoms, stressors)

Mental Health History:

(onset, symptoms, previous treatment)

Risk Factors:

Psychosocial History:

Child Development: (prenatal, perinatal and developmental milestones)

Educational information

Abuse History

Substance Abuse History

Previous Placement History (i.e., foster care, hospitals, relatives)

Family History/Caregivers

Medical History:

Pediatrician Name **Phone #** **Fax #**

Significant medical problems or concern (by history)

Current medical problems/concerns

Allergies

Dietary Restrictions/Modifications

Medication/hospitalization

Nutritional Needs

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Child and Family Strengths: (e.g., skills, personality traits, intelligence, resiliency, insight, etc.)

Behavioral Observations

	Okay	Possible Concern	Concern	Comments
Temperament and character				
Attention and concentration				
Attachment				
Autonomy and develop of self				
Self regulation				
Social/emotional				
Play				
Sensory Processing				
Self Help				
Motor				
Thought				
Communication				
Learning rules				
Parenting style				

Mental Health Comments/Conclusions: (optional)

Interpretation of Scores/Conclusions:

Date of Screening:
 Screening provided in:
 English Interpreter assisted in:
 Spanish
 Vietnamese
 Other:

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Screening Tools

- Brigance Early/Preschool Screen II
- Speech/Language Screen
- Motor Screen
- Sensory Processing Screen
- Other: _____
- Observation of child
- Interview with _____
- Chart Review of ASQ and ASQ:SE scores
- Edinburgh Depression Scale

Developmental Screening Results

	Okay	Possible Concern	Concern	Comments
Articulation (correctly produces all speech sounds for age)				
Language (correctly uses and understands words)				
Fluency (speech has a natural flow)				
Voice (volume, pitch and quality appropriate)				
Pre-academic skills (pre-reading, pre-writing, pre-math)				
Gross motor skills (arm and leg movements)				
Fine motor skills (hand and finger movements)				
Sensory Processing (self-regulation & response to environment)				

*CNS = Could Not Screen *NS = Not Screened

Hearing Screening

Loudness Level: 20dB Pass

Comments:

	500Hz	1000Hz	2000Hz	3000Hz	4000Hz
Right ear					
	500Hz	1000Hz	2000Hz	3000Hz	4000Hz
Left ear					

- ✓ A check mark (✓) indicates that the child responded.
- A hash mark (-) indicates that the child did NOT respond.

Vision Screening

Comments:

Right eye	<input type="checkbox"/> Pass	<input type="checkbox"/> Refer
Left eye	<input type="checkbox"/> Pass	<input type="checkbox"/> Refer

Oral Peripheral Check:

Observation of oral structures

- ✓ Tonsils _____
- ✓ Teeth _____
- ✓ Tongue _____
- ✓ Palate _____

Comments:

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Integrated Developmental and Mental Health Summary:

Areas of concern emerging from Assessment for Intervention:

<input type="checkbox"/> Affect <input type="checkbox"/> Autism spectrum <input type="checkbox"/> Engagement <input type="checkbox"/> Motor development <input type="checkbox"/> Self regulation <input type="checkbox"/> Trauma	<input type="checkbox"/> Attention <input type="checkbox"/> Behavior <input type="checkbox"/> Family system <input type="checkbox"/> Parent / child interaction <input type="checkbox"/> Speech / language delay <input type="checkbox"/> Vision / hearing	<input type="checkbox"/> Anxiety <input type="checkbox"/> Cognition and learning <input type="checkbox"/> Health <input type="checkbox"/> Parenting <input type="checkbox"/> Social skills <input type="checkbox"/> No concerns	<input type="checkbox"/> Attachment <input type="checkbox"/> Concentration <input type="checkbox"/> Mood <input type="checkbox"/> Self care <input type="checkbox"/> Temperament
<input type="checkbox"/> Other: _____			

Recommendations /Strategies for Continued Successful Development and Referrals:

<input type="checkbox"/> Anticipatory guidance <input type="checkbox"/> Hearing <input type="checkbox"/> Parent education <input type="checkbox"/> SARC <input type="checkbox"/> Vision	<input type="checkbox"/> Dental <input type="checkbox"/> Home visitation <input type="checkbox"/> PHP <input type="checkbox"/> School District: _____	<input type="checkbox"/> Early Start Program <input type="checkbox"/> Targeted Diagnostic Assessment <input type="checkbox"/> Preschool <input type="checkbox"/> Therapeutic services
<input type="checkbox"/> Other _____		

Consultants/Participants:

Date of Report: _____

- | | |
|---|--|
| <input type="checkbox"/> (MH Clinician)
Title, phone

<input type="checkbox"/> Rosa Gonzalez
Bilingual Educator
(408) 243-7861 Ext. 246

<input type="checkbox"/> Desiree Q Luong
Bilingual Educator
(408) 243-7861 Ext. 248

<input type="checkbox"/> Mayra Arango
Bilingual Early Childhood Educator
(408) 243-7861 Ext. 240 | <input type="checkbox"/> Rosie MacFarlane B.A. C.C.I. Permit
Bi-Lingual Preschool Resource Teacher
(408) 243-7861 RExt. 222

<input type="checkbox"/> Maggie Newman, MA, OTR/L
Occupational Therapist
(408) 243-7861 Ext.221 |
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This page is **for internal KidScope documentation purposes only**. PLEASE do not attach this page to the preceding report which is an effort to give families and service providers appropriate and user-friendly information

Medical Necessity Criteria

Have at least one of the following impairments as a result of a mental health disorder: A) A significant impairment in an important area of life functioning; B) A reasonable probability of significant deterioration in an important area of life functioning; C) Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this Section, a child is a person under the age of 21 years.

Check all that apply:

✓	Area	Brief Description of Impairment (if checked)
	Health (e.g., physical condition, activities of daily living)	
	Daily Activities (e.g., work, school, leisure)	
	Social Relationships (e.g., significant other, family, friends, support system)	
	Living Arrangement (e.g., homeless, maintaining current housing situation)	

DC 0-3 R Diagnosis (when applicable/appropriate)

Axis I	
Axis II	
Axis III	
Axis IV	
Axis V	Emotional and Social Functioning



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Diagnosis Summary

The name of the disorder according to DSM 5 classification followed by the numerical ICD-10 code and description. Example: (Primary) DSM 5: Major Depressive Disorder, Moderate. ICD-10: F33.1, Major depressive disorder, recurrent, moderate.

Each diagnosis must be stated clearly and legibly, and primary and secondary diagnosis (if applicable) must be identified. Please follow the State guidelines for primary and secondary diagnoses for mental health clients. *(Please note that each diagnosis given and documented in this section must be substantiated and supported by symptoms, behaviors, and functional impairments in the assessment form under the appropriate sections, usually under presenting problems and medical necessity.)*

Person completing Assessment:		
Signature	Discipline	Date
Review/Approval by Licensed Professional of the Healing Arts (if different from above):		
Signature	Discipline	Date

Santa Clara County Mental Health Department KidConnections Network of Care Initial Mental Health Assessment October 2015 MHD QI - Form #38	Program (Cost Center) _____ 6
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