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:

☐ Family Court	☐ Family Wellness Court	☐ DDTC	☐ DR ☐Path 1 ☐Path 2	
☐ HRIF	☐ IND	☐ Kidscope	☐SARC	☐Pediatrician
☐Early Start	☐ Head Start	☐ F5 Parent Workshop	☐F5 FRC	☐Head Start Non-PoP

Referring Person:	Referrer Agency/School:	Referrer Phone:	Referrer E-Mail:

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
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other:

☐ Interpreter assisted in:

Mental Health Department VALLEY Santa Clara Valley Health & Hospital System

kid Connections

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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

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

Comments:

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

Vision Screening

Right eye	☐ Pass	☐ Refer
Left eye	☐ Pass	☐ Refer

Comments:

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:

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

Recommendations /Strategies for Continued Successful Development and Referrals:

☐ Anticipatory guidance ☐ Hearing ☐ Parent education ☐ SARC ☐ Vision	☐ Dental ☐ Home visitation ☐ PHP ☐ School District: ____________________	☐ Early Start Program ☐ Targeted Diagnostic Assessment ☐ Preschool ☐ Therapeutic services
☐ Other		

Consultants/Participants: **Date of Report**: ______________

☐ (MH Clinician)
Title, phone

☐ Rosa Gonzalez
Bilingual Educator
(408) 243-7861 Ext. 246

☐ Rosie MacFarlane B.A. C.C.I. Permit
Bi-Lingual Preschool Resource Teacher
(408) 243-7861 RExt. 222

☐ Desiree Q Luong
Bilingual Educator
(408) 243-7861 Ext. 248

☐ Maggie Newman, MA, OTR/L
Occupational Therapist
(408) 243-7861 Ext.221

☐ Mayra Arango
Bilingual Early Childhood Educator
(408) 243-7861 Ext. 240

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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: F33.2, Recurrent Depressive Disorder, Current Episode 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