



KidConnections
Initial Mental Health Assessment-
Assessment for Intervention Report
 (Infant Toddler 0-24months)

Child's Name _____ Parent/Caregiver Name: _____
 Birthday: ____/____/____ Age: _____ Adjusted 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. and ways these may influence treatment)

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

Mental Health History:

(onset, symptoms, previous treatment)

Risk Factors:

Psychosocial History:

Pregnancy history (planned, desired, expectations, believes, habits, complications):

Birth (labor, complications, hospitalization, diagnosis, prognosis, evolution, recovery, medical surveillance, trauma)

APGAR, hearing test, vision

Child Development: (developmental milestones) Exploring/ interest

Abuse History

Parental Substance Abuse History

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

Family History/Caregivers

Educational information

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

Child and Family Strengths:

Santa Clara County Mental Health Department
 KidConnections Network of Care
 Initial Mental Health Assessment
 September 2015 MHD QI - Form #39

Program (Cost Center) _____



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Results of Screening Tools:

ASQ: **C** _____ /cut off: _____ **GM** _____ /cut off: _____ **FM** _____ /cut off: _____ **PS** _____ /cut off: _____ **S** _____ /cut off: _____
 ASQ-**SE**: _____ /cut off: _____
 CBCL:

Behavioral Observations

	Okay	Possible Concern	Concern	Comments
Temperament and character				
Physical Regulation (Changes in State, Coloration, Muscle tone, Reflexes, Positioning, Sleeping, Feeding, Digestion, Breathing, Crying, Mouthing, Temperature Regulation)				
Eye gaze				
Exploring/ interest				
Attention and concentration				
Emotional Regulation (Facial expression, Level of arousal, Activity, Alertness)				
Attachment				
Affect, Mood and Preferences: (pleasure, distress, self soothing)				
Engagement Capacities (communication, vocalization, social behavior, play)				
Quality of play (toddlers)				
Thought (toddlers)				
Autonomy and development of self (toddlers)				
Learning rules (toddlers)				
Attunement with primary caregiver				
Parent-child, physical connection and touch				



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Caregiver	
Sense of mastery reading infant cues	
Sense of mastery meeting infant basic needs, confidence in parental role	
Affection/ empathy Facial expressions	
Parent Emotional state Social Support	
Rhythm of Interactions Affective flow	
Parenting style Level of stimulation of child	
Mental Health Comments/Conclusions: (optional)	

Interpretation of Scores/Conclusions:

Date of Screening:
 Screening provided in:

- English Interpreter assisted in:
 Spanish
 Vietnamese
 Other:

Screening Tools

- | | |
|--|--|
| <input type="checkbox"/> <u>Brigance Infant Toddler Screen</u> | <input type="checkbox"/> Observation of child |
| <input type="checkbox"/> Speech/Language Screen | <input type="checkbox"/> Interview with _____ |
| <input type="checkbox"/> Motor Screen | <input type="checkbox"/> Chart Review of ASQ and ASQ:SE scores |
| <input type="checkbox"/> Sensory Processing Screen | <input type="checkbox"/> Edinburgh Depression Scale |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Parent Stress Index |



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Developmental Screening Results

	Okay	Possible Concern	Concern	Comments
Receptive Language / Communication under 18 months				
Expressive Language / not used under 18 months				
Muscle tone, reflexes,				
Gross motor skills (arm and leg movements)				
Fine motor skills (hand and finger movements)				
Self help skills				
Sensory Processing (self-regulation & response to environment)				

*CNS = Could Not Screen *NS = Not Screened

Comments:

Communication

Motor

Sensory Processing

Oral Peripheral Check:

Observation of oral structures

Comments:

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

Integrated Mental Health and Developmental Summary:

Areas of concern emerging from Assessment for Intervention:			
<input type="checkbox"/> Affect	<input type="checkbox"/> Attention	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Attachment
<input type="checkbox"/> Autism spectrum	<input type="checkbox"/> Behavior	<input type="checkbox"/> Cognition and learning	<input type="checkbox"/> Concentration
<input type="checkbox"/> Engagement	<input type="checkbox"/> Family system	<input type="checkbox"/> Health	<input type="checkbox"/> Mood
<input type="checkbox"/> Motor development	<input type="checkbox"/> Parent / child	<input type="checkbox"/> Parenting	<input type="checkbox"/> Self care
<input type="checkbox"/> Self regulation	<input type="checkbox"/> interaction	<input type="checkbox"/> Social skills	<input type="checkbox"/> Temperament

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<input type="checkbox"/> Trauma	<input type="checkbox"/> Speech / language delay <input type="checkbox"/> Vision / hearing	<input type="checkbox"/> No concerns	
<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)
<input type="checkbox"/>	Health (e.g., physical condition, activities of daily living)	
<input type="checkbox"/>	Daily Activities (e.g., work, school, leisure)	
<input type="checkbox"/>	Social Relationships (e.g., significant other, family, friends, support system)	
<input type="checkbox"/>	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