

# Request for Mental Health Observation or Consultation



Date: \_\_\_\_\_ Center: \_\_\_\_\_ Site: \_\_\_\_\_

Family SS/Advocate: \_\_\_\_\_ Teacher: \_\_\_\_\_

Staff initiating this request: \_\_\_\_\_ Phone: \_\_\_\_\_

Child: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address, City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Best times to call: \_\_\_\_\_ Best phone number: \_\_\_\_\_

ASQ Score(s): \_\_\_\_\_ ASQ-SE Score(s): \_\_\_\_\_

Center concerns regarding the child (behaviors, feelings etc.):

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Parent concerns regarding the child or family (behaviors, parenting, stress, etc.):

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Fax or Mail to Alex Clifthorne or Kristin Wells

Fax: 425-917-7766 / 253-778-7766

Mail: 800 Oakesdale Ave SW, Renton, WA 98057

***\*\*\*Do NOT email if this document contains child or family-specific confidential information\*\****