

# Tulane Early Childhood Collaborative

## Mental Health Consultation Request Form

**TECC can provide consultation by phone, email, and, when there are ongoing questions after these indirect consultations, in person with the child and family.** For “indirect” consultations (discussions with providers), please provide AGE in MONTHS, RACE, and ZIP CODE. We do not need other identifying information unless you are referring for in-person consultation (or anticipating requesting in person consultation after discussion with the TIMHS team).

If questions remain after indirect consultation, in-person consultations may be arranged.

**In Person Consultation:** Parents should be informed that a referral is being made and that the consultation will take place in New Orleans, LA at 131 South Robertson, New Orleans, LA 70112. It is important that families understand that this is a one-time consultation evaluation and that the TIMHS team will not provide direct treatment to the child. The consultation appointment will take approximately 2 hours. A parent or legal guardian must accompany the child to the appointment. Once we receive the referral we will contact the family to schedule a date and time for the evaluation and inform you of the date and time as well. Following the evaluation you will receive a report with recommendations regarding further clinical care and we will provide recommendations to the family as well.

FORM CAN BE COMPLETED AS FILLABLE PDF OR BY HAND.

Date of consultation:

### Practice/Agency Information

Practice/Agency Name:

Consulting Provider Name:

Best time to reach you to schedule consultation call:

Best Phone number:

Fax number for report:

### **Required Consultation Information**

Child Date of Birth or age in years and months:

Child Race  Caucasian  African American  Native American  Pacific Islander  Multi-racial  Other

Child Ethnicity:  Hispanic/Latino  Not Hispanic/Latino

Child Zip Code :

**Insurance Status if known** (note: this does not affect consultation process. We serve all children)

### Bayou health plan

Amerigroup   Amerihealth   Community Health Solutions   LA Health Care Connections   United Medicaid  
Legacy Medicaid   Unknown   None

### Private

Aetna   Blue Cross   Coventry   Humana   United   Other/Don't know

**Pertinent Medical History:**

**Type of consultation question:**

- Diagnostic
- Child care recommendations
- Resources-community access
- Medication question
- Non-patient related mental health question
- Advice for parent
- Other, please specify:

**What have you done to assess and/or treat this clinical issue to date and what were the results?**

- Structured screening tool (tool: ) Behavioral intervention ( )
- Teacher screening tool (tool: ) Medication ( )

Is the child receiving any therapeutic, community, or social services? Please specify:

Consultation question/Request (please include as much detail as possible)

**Patient information (ONLY IF IN-PERSON CONSULTATION):**

- Child/Client name:
- Pertinent Parent/Guardian name:
- Parent address:
- Best Parent contact number(s): ( Home Cell)
- Parent is aware of and agrees to the consultation and understands that TECC will not take over care of the patient

**Please FAX to TECC at (504) 988-4264. Please free to attach additional pages or information or FAX any additional information from the medical record that would be helpful.**