 

Infant Mental Health Quarterly Report

**Agency: Completed By:**

**Fiscal Year: Quarter:** [ ]  **Q1** [ ]  **Q2** [ ]  **Q3** [ ]  **Q4**

**Number of Referrals: \_\_\_\_**

**Referral Type & Number: FIT\_\_\_ CARA\_\_\_ Home Visiting\_\_\_ Self Referred\_\_\_**

**Protective Services\_\_\_ Child Care\_\_\_ Other\_\_\_**

**Number of referrals screened out of IMH CPP & referred to other services: \_\_\_\_\_**

1. ***Describe the agency’s programmatic, clinical and/or case specific successes and improvements for this quarter:***
2. ***Describe the agency’s programmatic, clinical and/or case specific challenges or setbacks for this quarter:***
3. ***Please describe any additional support needed?***