

6 MONTHS

If the child is missing ONE or more of the following expected age outcomes or has any **RED FLAGS, complete this form and **fax to 905-762-2099**.**

YES NO	YES NO
<input type="checkbox"/> <input type="checkbox"/> Orients to sounds	<input type="checkbox"/> <input type="checkbox"/> Looks around and is alert to surroundings
<input type="checkbox"/> <input type="checkbox"/> Startles in response to loud noises	<input type="checkbox"/> <input type="checkbox"/> Rolls from back to stomach or stomach to back
<input type="checkbox"/> <input type="checkbox"/> Makes different cries for different needs (i.e. hungry, tired)	<input type="checkbox"/> <input type="checkbox"/> Pushes up on hands when on tummy
<input type="checkbox"/> <input type="checkbox"/> Watches your face as you talk	<input type="checkbox"/> <input type="checkbox"/> Keeps head level when pulled to sitting position
<input type="checkbox"/> <input type="checkbox"/> Smiles/laughs in response to your smiles and laughter	<input type="checkbox"/> <input type="checkbox"/> Brings hands or toy to mouth
<input type="checkbox"/> <input type="checkbox"/> Imitates coughs or other sounds (e.g. "ah", "eh", "buh")	<input type="checkbox"/> <input type="checkbox"/> Reaches for familiar person or toy
<input type="checkbox"/> <input type="checkbox"/> Tracks lights visually	<input type="checkbox"/> <input type="checkbox"/> Transfers object from one hand to the other
	<input type="checkbox"/> <input type="checkbox"/> Eats from a spoon (e.g. infant cereal)

RED FLAGS:

<input type="checkbox"/> If the child has lost any previously obtained skills <input type="checkbox"/> Rarely engages socially (e.g. smiling, eye contact)	<input type="checkbox"/> More interested in looking at objects than people's faces <input type="checkbox"/> Any difficulty with feeding or swallowing
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FAMILY INFORMATION

CHILD'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

PARENT(S) NAME: _____ WORK#: _____ HOME#: _____

REFERRAL SOURCE

NAME: _____ PHONE#: _____ FAX#: _____

ADDRESS: _____

PARENT GUARDIAN CONSENT

I _____ consent to a referral being made to York Region Preschool Speech & Language Program and/or Early Intervention Services for my child _____.

Signature: _____ Date: _____