

## 9 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"/> Responds to his/her name	<input type="checkbox"/> <input type="checkbox"/> Looks for dropped objects
<input type="checkbox"/> <input type="checkbox"/> Responds to telephone ringing or a knock at the door	<input type="checkbox"/> <input type="checkbox"/> Sits without support for a few minutes
<input type="checkbox"/> <input type="checkbox"/> Understands being told "no"	<input type="checkbox"/> <input type="checkbox"/> Moves forward while on stomach/ starting to crawl
<input type="checkbox"/> <input type="checkbox"/> Gets what she/he wants through gestures (e.g. reaching to be picked up)	<input type="checkbox"/> <input type="checkbox"/> Travels by rolling, scooting or creeping
<input type="checkbox"/> <input type="checkbox"/> Plays social games with you (e.g. "Peek-A-Boo")	<input type="checkbox"/> <input type="checkbox"/> Stands while holding onto something
<input type="checkbox"/> <input type="checkbox"/> Babbles and repeats sounds such as "babababa" or "duhduhduh"	<input type="checkbox"/> <input type="checkbox"/> Picks up small objects using tips of thumb and index finger
<input type="checkbox"/> <input type="checkbox"/> Feeds self cracker or cookie	<input type="checkbox"/> <input type="checkbox"/> Releases objects voluntarily
<input type="checkbox"/> <input type="checkbox"/> Mouths and chews on objects	<input type="checkbox"/> <input type="checkbox"/> Bangs two objects together or claps

### RED FLAGS:

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

### 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: \_\_\_\_\_