



Community and Health Services
Early Intervention Services



**EARLY REFERRAL
IDENTIFICATION KIT**



**York Region Preschool
Speech and Language Program**

12 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"/>	Follows simple one-step directions (e.g. "sit down")	<input type="checkbox"/>	<input type="checkbox"/>	Combines a lot of sounds together as though talking (e.g. "abada baduh abee")
<input type="checkbox"/>	<input type="checkbox"/>	Looks across the room to a toy when adult points at it	<input type="checkbox"/>	<input type="checkbox"/>	Shows an interest in simple picture books
<input type="checkbox"/>	<input type="checkbox"/>	Uses 3-5 words even if not accurate	<input type="checkbox"/>	<input type="checkbox"/>	Walks holding onto furniture
<input type="checkbox"/>	<input type="checkbox"/>	Uses gestures to communicate (e.g. waves hi/bye, shakes head "no")	<input type="checkbox"/>	<input type="checkbox"/>	Stands alone
<input type="checkbox"/>	<input type="checkbox"/>	Gets your attention using sounds, gestures and pointing while looking at your eyes	<input type="checkbox"/>	<input type="checkbox"/>	Helps a little when being dressed (e.g. extends arm to put in sleeve)
<input type="checkbox"/>	<input type="checkbox"/>	Brings/extends toys to show you	<input type="checkbox"/>	<input type="checkbox"/>	Turns pages of book a few at a time
<input type="checkbox"/>	<input type="checkbox"/>	"Performs" for social attention and praise	<input type="checkbox"/>	<input type="checkbox"/>	Removes objects from containers (e.g. blocks, toys, food)
<input type="checkbox"/>	<input type="checkbox"/>	Plays social games/songs (e.g. patty-cake, peek-a-boo)	<input type="checkbox"/>	<input type="checkbox"/>	Lifts bottle/sippy cup to mouth and drinks (two hands)
				<input type="checkbox"/>	Picks up and eats finger foods

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"/> Inconsistent/or no response when name is called	<input type="checkbox"/> Any difficulty eating solids or swallowing
<input type="checkbox"/> Rarely engages socially (e.g. smiling, eye contact)	

FAMILY INFORMATION

CHILD'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ POSTAL CODE: _____

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

REFERRAL SOURCE

NAME: _____ PHONE #: _____ FAX #: _____

ADDRESS: _____ POSTAL CODE: _____

EMAIL: _____

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: _____