

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 cup to mouth and drinks (two hands)
	<input type="checkbox"/> <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"/> 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: _____
 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: _____