



Community and Health Services  
Early Intervention Services



**EARLY REFERRAL  
IDENTIFICATION KIT**



York Region Preschool  
Speech and Language Program

**18 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"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses at least 20 words consistently even if not clear (e.g. labeling food, toys, people)		Enjoys being read to and sharing simple books with you	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Makes at least 4 different consonant sounds (e.g. p, b, m, n, d, g, w, h)		Demonstrates some pretend play with toys (e.g. gives teddy a drink, pretends a bowl is a hat)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Responds with words or gestures to simple questions (e.g. "Where's teddy?", "What's that?")		Walks alone (feet may have wide gait)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understands the concepts of "in & out", "off & on"		Walks up and down stairs with assistance	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Points to three or more body parts when asked		Climbs onto low step, table or stool	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Points to familiar pictures using one finger		Likes to retrieve and carry objects	
		<input type="checkbox"/>	<input type="checkbox"/>
		Takes off own socks and hat	
		<input type="checkbox"/>	<input type="checkbox"/>
		Fits objects together (e.g. pegs, nesting cups)	
		<input type="checkbox"/>	<input type="checkbox"/>
		Brings spoon to mouth in attempts to self feed	

**RED FLAGS:**

The child has lost any previously obtained skills

Inconsistent/no response when name is called

Rarely engages socially (e.g. smiling, eye contact)

More interested in looking at objects than people's faces

Difficulty eating solids or swallowing

Lack of interest in toys or usually plays with them in an unusual way (e.g. lining up, spinning, opening/closing parts rather than using the toy as a whole)

Preoccupation with unusual interests such as light switches, doors, fans, wheels

Unusual interest in letters or numbers and/or may show some ability to recognize words in print - but no clear indication of comprehension

**STUTTERING:**

Parents report child "stutters" using repetitions of words (e.g. "I I I") or syllables (e.g. "dadadaddy"), sound prolongations (e.g. "mmmmommy) or blocks (e.g. "b----all")

**VOICE:**

Unusual quality

**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: \_\_\_\_\_

**FOR INTAKE USE ONLY** • REFERRAL SOURCE CONFIRMATION: \_\_\_\_\_ Date: \_\_\_\_\_

FILE OPENED FOR EARLY INTERVENTION AND/OR SPEECH AND LANGUAGE  PARENT DECLINED  FAMILY COULD NOT BE REACHED