

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

<input type="checkbox"/> The child has lost any previously obtained skills <input type="checkbox"/> Inconsistent/no response when name is called <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"/> Difficulty eating solids or swallowing <input type="checkbox"/> Lack of interest in toys or plays with them in an unusual way (e.g. lining up, spinning, opening/closing parts rather than using the toy as a whole)	<input type="checkbox"/> Preoccupation with unusual interests such as light switches, doors, fans, wheels  <p><b style="color: red;">STUTTERING:</b></p> <input type="checkbox"/> <i>Parents report child "stutters" using repetitions of words (e.g. "lll") or syllables (e.g. "dadadaddy"), sound prolongations (e.g. "mmmommy) or blocks (e.g. "b----all").</i> <p><b style="color: red;">VOICE:</b></p> <input type="checkbox"/> <i>Unusual quality</i>
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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: \_\_\_\_\_