



Community and Health Services
Early Intervention Services



EARLY REFERRAL
IDENTIFICATION KIT



York Region Preschool
Speech and Language Program

6 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"/>	Orients to sounds	<input type="checkbox"/>	<input type="checkbox"/>	Looks around and is alert to surroundings
<input type="checkbox"/>	<input type="checkbox"/>	Startles in response to loud noises	<input type="checkbox"/>	<input type="checkbox"/>	Rolls from back to stomach or stomach to back
<input type="checkbox"/>	<input type="checkbox"/>	Makes different cries for different needs (i.e. hungry, tired)	<input type="checkbox"/>	<input type="checkbox"/>	Pushes up on hands when on tummy
<input type="checkbox"/>	<input type="checkbox"/>	Watches your face as you talk	<input type="checkbox"/>	<input type="checkbox"/>	Keeps head level when pulled to sitting position
<input type="checkbox"/>	<input type="checkbox"/>	Smiles/laughs in response to your smiles and laughter	<input type="checkbox"/>	<input type="checkbox"/>	Brings hands or toy to mouth
<input type="checkbox"/>	<input type="checkbox"/>	Imitates coughs or other sounds (e.g. "ah", "eh", "buh")	<input type="checkbox"/>	<input type="checkbox"/>	Reaches for familiar person or toy
<input type="checkbox"/>	<input type="checkbox"/>	Tracks lights visually	<input type="checkbox"/>	<input type="checkbox"/>	Transfers object from one hand to the other
			<input type="checkbox"/>	<input type="checkbox"/>	Eats from a spoon (e.g. infant cereal)

RED FLAGS:

- If the child has lost any previously obtained skills
- Rarely engages socially (e.g. smiling, eye contact)
- More interested in looking at objects than people's faces
- Any difficulty with feeding or swallowing

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: _____

CONSENT

- Verbal consent provided by parent/guardian

The Children's Treatment Network Developmental Assessment and Consultation Services (DACs)

- No referral indicated at this time Referral has been made by doctor Referral to be initiated by Early Intervention Services

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