



Community Services and Housing
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:

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

FAMILY INFORMATION

CHILD'S NAME: _____ DATE OF BIRTH: _____
 ADDRESS: _____ POSTAL CODE: _____
 PARENT(S) NAME: _____ WORK#: _____ HOME#: _____

REFERRAL SOURCE

NAME: _____ PHONE#: _____ FAX#: _____
 ADDRESS: _____ POSTAL CODE: _____

CONSENT

- Verbal consent provided by parent /guardian

THE CHILDREN'S TREATMENT NETWORK DEVELOPMENT ASSESSMENT AND CONSULTATION SERVICES (DACS)
formerly the Paediatric Developmental Assessment Clinic

- No referral indicated at this time Referral has been made by doctor Referral to be initiated by Central Intake Line