



Community and Health Services
Early Intervention Services



EARLY REFERRAL
IDENTIFICATION KIT



York Region Preschool
Speech and Language Program

9 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"/>	Responds to his/her name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Looks for dropped objects
<input type="checkbox"/>	<input type="checkbox"/>	Responds to telephone ringing or a knock at the door	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sits without support for a few minutes
<input type="checkbox"/>	<input type="checkbox"/>	Understands being told "no"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Moves forward while on stomach/ starting to crawl
<input type="checkbox"/>	<input type="checkbox"/>	Gets what she/he wants through gestures (e.g. reaching to be picked up)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Travels by rolling, scooting or creeping
<input type="checkbox"/>	<input type="checkbox"/>	Plays social games with you (e.g. "Peek-A-Boo")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stands while holding onto something
<input type="checkbox"/>	<input type="checkbox"/>	Babbles and repeats sounds such as "babababa" or "duhduhduh"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Picks up small objects using tips of thumb and index finger
<input type="checkbox"/>	<input type="checkbox"/>	Feeds self cracker or cookie	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Releases objects voluntarily
<input type="checkbox"/>	<input type="checkbox"/>	Mouths and chews on objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bangs two objects together or claps

RED FLAGS:

- 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 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