

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"/> 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"/> Sits without support for a few minutes
<input type="checkbox"/> <input type="checkbox"/> Understands being told "no"	<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"/> 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"/> 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"/> 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"/> Releases objects voluntarily
<input type="checkbox"/> <input type="checkbox"/> Mouths and chews on objects	<input type="checkbox"/> <input type="checkbox"/> Bangs two objects together or claps

RED FLAGS:

- | | |
|--|--|
| <input type="checkbox"/> 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 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