



Community and Health Services
Early Intervention Services



EARLY REFERRAL
IDENTIFICATION KIT



York Region Preschool
Speech and Language Program

12 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"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follows simple one-step directions (e.g. "sit down")		Combines a lot of sounds together as though talking (e.g. "abada baduh abee")	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looks across the room to a toy when adult points at it		Shows an interest in simple picture books	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses 3-5 words even if not accurate		Walks holding onto furniture	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses gestures to communicate (e.g. waves hi/bye, shakes head "no")		Stands alone	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets your attention using sounds, gestures and pointing while looking at your eyes		Helps a little when being dressed (e.g. extends arm to put in sleeve)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brings/extends toys to show you		Turns pages of book a few at a time	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
"Performs" for social attention and praise		Removes objects from containers (e.g. blocks, toys, food)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plays social games/songs (e.g. patty-cake, peek-a-boo)		Lifts bottle/sippy cup to mouth and drinks (two hands)	
		<input type="checkbox"/>	<input type="checkbox"/>
		Picks up and eats finger foods	

RED FLAGS:

- The child has lost any previously obtained skills
- Inconsistent/or no response when name is called
- Rarely engages socially (e.g. smiling, eye contact)
- More interested in looking at objects than people's faces
- Any difficulty eating solids 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