



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

### 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"/> No response when name is called                     | <input type="checkbox"/> Any difficulty eating solids or swallowing                |
| <input type="checkbox"/> Rarely engages socially (e.g. smiling, eye contact) |  |

### 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