York Region
Community Services and Housing
Early Intervention Services

# ERIK
EARLY REFERRAL
IDENTIFICATION KIT

MARKHAM STOUFFVILLE HOSPITAL CORPORATION
York Region Preschool
Speech and Language Program

# 18 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 | |
|---|---|---|
| ❑ | ❑ | Uses at least 20 words consistently even if not clear (e.g. labeling food, toys, people) |
| ❑ | ❑ | Makes at least 4 different consonant sounds (e.g. p, b, m, n, d, g, w, h) |
| ❑ | ❑ | Responds with words or gestures to simple questions (e.g. "Where's teddy?", "What's that?") |
| ❑ | ❑ | Understands the concepts of "in & out", "off & on" |
| ❑ | ❑ | Points to three or more body parts when asked |
| ❑ | ❑ | Points to familiar pictures using one finger |

| YES | NO | |
|---|---|---|
| ❑ | ❑ | Enjoys being read to and sharing simple books with you |
| ❑ | ❑ | Demonstrates some pretend play with toys (e.g. gives teddy a drink, pretends a bowl is a hat) |
| ❑ | ❑ | Walks alone (feet may have wide gait) |
| ❑ | ❑ | Walks up and down stairs with assistance |
| ❑ | ❑ | Climbs onto low step, table or stool |
| ❑ | ❑ | Likes to retrieve and carry objects |
| ❑ | ❑ | Takes off own socks and hat |
| ❑ | ❑ | Fits objects together (e.g. pegs, nesting cups) |
| ❑ | ❑ | Brings spoon to mouth in attempts to self feed |

## RED FLAGS:

- ❑ The child has lost any previously obtained skills
- ❑ Inconsistent/no response when name is called
- ❑ Rarely engages socially (e.g. smiling, eye contact)
- ❑ More interested in looking at objects than people's faces
- ❑ Difficulty eating solids or swallowing
- ❑ Lack of interest in toys or plays with them in an unusual way (e.g. lining up, spinning, opening/closing parts rather than using the toy as a whole)
- ❑ Preoccupation with unusual interests such as light switches, doors, fans, wheels

### *STUTTERING:*

- ❑ ***Parents report child "stutters" using repetitions of words (e.g."I I I") or syllables (e.g. "dadadaddy"), sound prolongations (e.g. "mmmommy) or blocks (e.g. "b----all").***

### *VOICE:*

- ❑ ***Unusual quality***

## 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