



Community and Health Services
Early Intervention Services



EARLY REFERRAL
IDENTIFICATION KIT



York Region Preschool
Speech and Language Program

36 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"/>	Understands "who", "what", "where", and "why" questions	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Creates long sentences (e.g. using 5 to 8 words)	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Talks about past events (e.g. trip to Grandparents' house, day at childcare)	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Tells simple stories	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Beginning interest in, and awareness of, rhyming	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Understood by most people outside of the family most of the time	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Names one or more colours	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Shows affection for favourite playmates	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Joins in play with a group of two or more peers	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Engages in multi-step pretend play (e.g. pretending to cook a meal, repair a car, etc)	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Listens to stories or music for 5 minutes with adult	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Aware of the function of print (e.g. in menus, lists, signs)	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Gets up from squatting position without help	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Rides around on a tricycle, using pedals	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Stands on one foot with momentary balance	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Completes an easy puzzle (4-6 pieces)	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Copies a circle from a model	<input type="checkbox"/>

RED FLAGS:

- The child has lost any previously obtained skills, language or social 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
- Lack of interest in toys or usually 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
- Unusual interest in letters or numbers. May show some ability to recognize words in print - but no clear indication of comprehension

- Talks in "whole phrases" or "scripts" from TV shows or books, when these do not seem relevant to the situation
- Echoing others' phrases or sentences (for example: parent says "put on your shoes"; child responds "put on your shoes")
- Compulsions or rituals (has to perform activities in a special way or certain sequence: is prone to temper tantrums if rituals are interrupted)

STUTTERING:

- Parents report child "stutters" using repetitions of words (e.g. "lll") or syllables (e.g. "dadadaddy"), sound prolongations (e.g. "mmmmommy) 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 #: _____ 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