

## 60 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**.

*\* No longer eligible for service by York Region Preschool Speech and Language Program.*

*If concerned, parents to contact child's school for referral to School Board Speech Language Pathologist.*

YES NO	YES NO
<input type="checkbox"/> <input type="checkbox"/> Follows group directions (e.g. "all the boys get a toy")	<input type="checkbox"/> <input type="checkbox"/> Will play with a variety of toys/games/materials
<input type="checkbox"/> <input type="checkbox"/> Understands directions involving "if...then" (e.g. "If you're wearing a red shirt, then line up for gym")	<input type="checkbox"/> <input type="checkbox"/> Walks up stairs alternating feet
<input type="checkbox"/> <input type="checkbox"/> Describes past, present and future events in detail	<input type="checkbox"/> <input type="checkbox"/> Hops with one foot without support
<input type="checkbox"/> <input type="checkbox"/> Uses almost all of the sounds of their language with few or no errors	<input type="checkbox"/> <input type="checkbox"/> Draws a stick person with at least 3 body parts (e.g. eyes, nose, mouth, head, body, arms and legs)
<input type="checkbox"/> <input type="checkbox"/> Seeks to please his/her friends	<input type="checkbox"/> <input type="checkbox"/> Strings a small set of beads
<input type="checkbox"/> <input type="checkbox"/> Shows increasing independence in friendships (e.g. may visit neighbour by him/herself)	<input type="checkbox"/> <input type="checkbox"/> Holds crayon/pencil correctly (between thumb and forefinger)
<input type="checkbox"/> <input type="checkbox"/> Knows all the letters of the alphabet	<input type="checkbox"/> <input type="checkbox"/> Prints first letter or more of name
<input type="checkbox"/> <input type="checkbox"/> Identifies the sounds at the beginning of some words (e.g. "Pop start with the "puh" sound")	<input type="checkbox"/> <input type="checkbox"/> Cuts and pastes
<input type="checkbox"/> <input type="checkbox"/> Plays with or at an activity for 20 minutes	<input type="checkbox"/> <input type="checkbox"/> Is okay with messy activities (e.g. paint, playdough, glue)
	<input type="checkbox"/> <input type="checkbox"/> Pours milk/juice from pitcher without spilling

### RED FLAGS:

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> The child has lost any previously obtained skills, language or social skills</li> <li><input type="checkbox"/> No response when name is called, causing concern about hearing</li> <li><input type="checkbox"/> Loss of any previously obtained language or social skills</li> <li><input type="checkbox"/> More interested in looking at objects than people's faces</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Rarely engages socially (e.g. smiling, eye contact)</li> <li><input type="checkbox"/> Preoccupation with unusual interests such as light switches, doors, fans, wheels</li> <li><input type="checkbox"/> Compulsions or rituals (has to perform activities in a special way or certain sequence: is prone to temper tantrums if rituals are interrupted)</li> </ul> <p style="color: red;"><b>Stuttering, voice or articulation: parents refer to School Board Speech Language Pathologist.</b></p> |
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### 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