Reset Form Print

York Region
Community and Health Services
Early Intervention Services

EARLY REFERRAL IDENTIFICATION KIT

MARKHAM STOUFFVILLE HOSPITAL CORPORATION
York Region Preschool Speech and Language Program

Referral for 12 Months

Date: _____ Child's Name:_____ Date of Birth_____
Parent(s) Name: _____
Home # _____ Work / Cell#_____ email: _____
Child's address_____ Postal Code_____

If the child has one or more flags, please fax your referral to Central Intake at 905-762-2115

Yes	No	
☐	☐	Follows simple 1-step directions e.g. "sit down"
☐	☐	Looks across the room to a toy when adult points to it
☐	☐	Uses specific gestures to communicate (e.g. waves hi/bye, shakes head "no")
☐	☐	Uses three or more "words" (same sounds to indicate same object or person)
☐	☐	Brings/ extends toys to show you
☐	☐	Gets your attention using sounds, gestures and pointing while looking at your eyes
☐	☐	Consistently points to request
☐	☐	"Performs" for social attention and praise
☐	☐	Plays social games with you (e.g. "Peek-A-Boo", "patty cake")
☐	☐	Combines a lot of sounds together as though talking (e.g. "abada badu abee")
☐	☐	Shows interest in simple picture books
☐	☐	Turns pages of books a few at a time
☐	☐	Removes objects from containers (e.g. food, blocks, toys)
☐	☐	Helps a little while being dressed (e.g. extends arm to put in sleeve)
☐	☐	Lifts cup to mouth with two hands to drink
☐	☐	Picks up and eats finger foods
☐	☐	Stands alone for 2 seconds or more
☐	☐	Walks sideways holding on to furniture
☐	☐	Lowers self from standing with control, not falling on bottom

Has anyone noticed whether the child

Yes	No	
☐	☐	Has lost any previously obtained skills
☐	☐	Has inconsistent/no response when name is called
☐	☐	Rarely engages socially (e.g. smiling, eye contact)
☐	☐	Is more withdrawn or more difficult to comfort than other children
☐	☐	Is more interested in looking at objects than people's faces
☐	☐	Has any difficulty with feeding, chewing or swallowing

REFERRAL SOURCE _____ **Phone:** _____ **Fax:** _____
Address: _____ **email:** _____

PARENT GUARDIAN CONSENT

I _____ consent to a referral being made to York Region Preschool Speech & Language Program and/or Early Intervention Services for my child _____ .
Signature: _____Date:_____
Notes:
_____

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