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York Region
Community and Health Services
Early Intervention Services

ERIK
EARLY REFERRAL IDENTIFICATION KIT

Markham Stouffville Hospital Corporation
York Region Preschool Speech and Language Program

Referral for 18 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	
☐	☐	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)
☐	☐	Imitates words and gestures
☐	☐	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
☐	☐	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
☐	☐	Stacks 3 blocks
☐	☐	Brings spoon to mouth in attempts to self feed

Has anyone noticed whether the child

Yes	No	
☐	☐	Has lost any previously obtained skills
☐	☐	Has inconsistent/no response when name is called
☐	☐	Tries to get your attention to show you what they are interested in
☐	☐	Consistently points to what he / she wants when it is out of reach
☐	☐	Looks for a toy when asked where it is or you point to it
☐	☐	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☐	☐	Is more withdrawn or more difficult to comfort than other children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
☐	☐	When eating has sensitivity to different textures OR difficulty chewing or swallowing
☐	☐	Lacks interest in toys or typically plays with them in an unusual way (e.g. lining up, spinning, opening/closing parts rather than using the toy as a whole)
☐	☐	Is preoccupied with unusual interests or topics (e.g. light switches, doors, fans, trains)
☐	☐	Shows an intense interest in letters or numbers and/or some ability to recognize untaught printed words
☐	☐	Moves his/her fingers, hands or body in an odd or repetitive way
☐	☐	STUTTERS: 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")
☐	☐	Has an unusual voice quality (e.g. nasal, hoarse, breathy)

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