

Referral for 24 Months

Date: _____ Child's Name: _____ Date of Birth _____
 Parent(s) Name: _____ Phone # _____ 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	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Uses 100 words or more
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Uses at least two pronouns (e.g. "you", "me", "mine")
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Consistently combines 2 to 4 words in short phrases (e.g. "Daddy hat", "Truck go down")
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Words are understood by others half the time
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Forms words and sounds easily and effortlessly
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Follows two-step directions (e.g. "Go find your teddy and show it to grandma")
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Enjoys being around and playing with other children (e.g. sharing or to offering toys to peers)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Begins to imitate peers' actions and words
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Holds book the right way up and turns pages one at a time
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Pretends by acting out daily and special routines with toys (e.g. cooking a meal or a birthday party)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Can run or walk fast
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Walks downstairs holding only onto parent's finger
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Kicks ball forward
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Tries to undress self (e.g. takes off/opens coat, pulls down pants)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Can throw a small ball overhand
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Scribbles with crayons / marks paper
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Feeds him/herself with a spoon, spilling little

Has anyone noticed whether the child

Yes	No	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Has lost any previously obtained skills, language or social skills
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Does not respond consistently or at all when name is called
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Rarely engages socially (e.g. smiling, eye contact)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Is more withdrawn or more difficult to comfort than other children
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Is more interested in looking at objects than people's faces
<input checked="" type="checkbox"/>	<input type="checkbox"/>	When eating, has sensitivity/aversions to different textures OR difficulty chewing or swallowing
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lacks interest in toys or typically plays with them in an unusual or repetitive way (e.g. lining up, spinning, opening/closing parts rather than using the toy in the expected way)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Is preoccupied with unusual interests or topics (e.g. light switches, doors, fans, trains)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Shows an intense interest in letters or numbers to the exclusion of a more typical way of interacting with an object (e.g. focussing on the words rather than the pictures in a book, or on the letters written on a toy vs. the toy itself)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Performs activities in a special way/certain order and may have a temper tantrum if this activity is interrupted
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Moves his/her fingers, hands or body in an odd or repetitive way
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Echoes other people's phrases or sentences (e.g. parent says "Put on your shoes" child responds "Put on your shoes")
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Talks in whole phrases or scripts from TV shows or books when these do not seem relevant to the situation
<input checked="" type="checkbox"/>	<input type="checkbox"/>	STUTTERS: Parents report child "stutters" using repetitions of words (e.g. "lll") or syllables (e.g. "dadadaddy"), sound prolongations (e.g. "mmmommy) or blocks (e.g. "b----all")
<input checked="" type="checkbox"/>	<input type="checkbox"/>	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