

Referral for 30 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 type="checkbox"/>	Uses 350 words or more
<input type="checkbox"/>	<input type="checkbox"/>	Speaks in sentences of at least 3 words
<input type="checkbox"/>	<input type="checkbox"/>	Uses some adult word-endings (e.g. "two cookies", "bird flying" "I jumped")
<input type="checkbox"/>	<input type="checkbox"/>	Uses action words (e.g. "run", "spill", "fall")
<input type="checkbox"/>	<input type="checkbox"/>	Listens to and understands simple stories and retells familiar stories
<input type="checkbox"/>	<input type="checkbox"/>	Understands concepts of size (big vs. little) and quantity (a little vs. a lot)
<input type="checkbox"/>	<input type="checkbox"/>	Uses consonant sounds at the beginning of words (e.g. <u>b</u> ig, <u>p</u> otty, <u>m</u> essy, <u>d</u> onut)
<input type="checkbox"/>	<input type="checkbox"/>	Produces words with two or more syllables or beats (e.g. "ba-na-na" "a-pple", "com-pu-ter")
<input type="checkbox"/>	<input type="checkbox"/>	Begins taking short turns with peers, using both words and toys
<input type="checkbox"/>	<input type="checkbox"/>	Shows concern when another child is hurt or sad
<input type="checkbox"/>	<input type="checkbox"/>	Pretend play involves several actions (e.g. feeds doll and then puts her to sleep)
<input type="checkbox"/>	<input type="checkbox"/>	Tries to join in with you when you sing songs or make rhymes
<input type="checkbox"/>	<input type="checkbox"/>	Recognizes self in mirror or photo
<input type="checkbox"/>	<input type="checkbox"/>	Opens a door by turning the knob
<input type="checkbox"/>	<input type="checkbox"/>	Copies horizontal / vertical line
<input type="checkbox"/>	<input type="checkbox"/>	Can walk up and down stairs without holding onto wall or railing
<input type="checkbox"/>	<input type="checkbox"/>	Dresses self with a little help
<input type="checkbox"/>	<input type="checkbox"/>	Feeds self with little mess using spoon or fork
<input type="checkbox"/>	<input type="checkbox"/>	Jumps with both feet off the floor

Has anyone noticed whether the child

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Has lost any previously obtained skills, language or social skills
<input type="checkbox"/>	<input type="checkbox"/>	Does not respond consistently or at all when name is called
<input type="checkbox"/>	<input type="checkbox"/>	Rarely engages socially (e.g. smiling, eye contact)
<input type="checkbox"/>	<input type="checkbox"/>	Is more interested in looking at objects than people's faces
<input type="checkbox"/>	<input type="checkbox"/>	When eating, has sensitivity/aversions to different textures OR difficulty chewing or swallowing
<input 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 type="checkbox"/>	<input type="checkbox"/>	Is preoccupied with unusual interests or topics (e.g. light switches, doors, fans, trains)
<input 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 type="checkbox"/>	<input type="checkbox"/>	Performs activities in a specific way/certain order and may have a temper tantrum if this activity is interrupted
<input type="checkbox"/>	<input type="checkbox"/>	Moves his/her fingers, hands or body in an odd or repetitive way
<input 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 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 type="checkbox"/>	<input type="checkbox"/>	STUTTERS: Parents report child "stutters" using repetitions of words (e.g. "I I I") or syllables (e.g. "dadadaddy"), sound prolongations (e.g. "mmmmommy) or blocks (e.g. "b----all")
<input 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: _____

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• REFERRAL SOURCE CONFIRMATION:

Date: _____

File opened for Early Intervention and/or Speech and Language

Parent declined

Family could not be reached