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 6 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	
☐	⚑	Orients to sounds
☐	⚑	Startles in response to loud noises
☐	⚑	Makes different cries for different needs (i.e. hungry, tired)
☐	⚑	Watches your face as you talk
☐	⚑	Smiles/laughs in response to your smiles and laughter
☐	⚑	Imitates coughs or other sounds (e.g. "ah", "eh", "buh")
☐	⚑	Tracks lights visually
☐	⚑	Looks around and is alert to surroundings
☐	⚑	Rolls from back to stomach or stomach to back
☐	⚑	Pushes up on hands when on tummy
☐	⚑	Keeps head level when pulled to sitting position
☐	⚑	Brings hands or toy to mouth
☐	⚑	Reaches for familiar person or toy
☐	⚑	Transfers object from one hand to the other
☐	⚑	Eats from a spoon (e.g. infant cereal)

Has anyone noticed whether the child

Yes	No	
⚑	☐	Has lost any previously obtained skills
⚑	☐	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⚑	☐	Is more withdrawn or more difficult to comfort than other children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 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