

Referral for 9 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	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Responds to his/her name
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Responds to telephone ringing or a knock at the door
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Understands being told "no"
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Gets what she/he wants through gestures (e.g. reaching to be picked up)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Plays social games with you (e.g. "Peek-A-Boo")
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Babbles and repeats sounds such as "babababa" or "duhduhduh"
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Feeds self cracker or cookie
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Mouths and chews on objects
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Looks for dropped objects or hidden toy
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Sits without support for a few minutes
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Moves forward while on stomach/ starting to crawl or rolls to get around the room
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Travels by rolling, scooting or creeping
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Stands while holding onto something
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Picks up small objects using tips of thumb and index finger
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Releases objects voluntarily
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Bangs two objects together or claps

Has anyone noticed whether the child

Yes	No	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Has lost any previously obtained skills
<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	Is more withdrawn or more difficult to comfort than other children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"/>	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

File opened for Early Intervention and/or Speech and Language

• REFERRAL SOURCE CONFIRMATION:

Parent declined

Date: _____

Family could not be reached