





Referral for 12 Months		
Date	:	Child's Name: Date of Birth
Parei	nt(s) N	Name:
		Work / Cell# email:
Child	's add	dressPostal Code
	If t	the child has one or more flags, please fax your referral to Central Intake at 905-762-2115
Yes	No	
	P	Follows simple 1-step directions e.g. "sit down"
	P	Looks across the room to a toy when adult points to it
	P	Uses specific gestures to communicate (e.g. waves hi/bye, shakes head "no")
	P	Uses three or more "words" (same sounds to indicate same object or person)
	P	Brings/ extends toys to show you
	P	Gets your attention using sounds, gestures and pointing while looking at your eyes
	P	Consistently points to request
	P	"Performs" for social attention and praise
	P	Plays social games with you (e.g. "Peek-A-Boo", "patty cake")
	P	Combines a lot of sounds together as though talking (e.g. "abada badu abee")
	P	Shows interest in simple picture books
	P	Turns pages of books a few at a time
	P	Removes objects from containers (e.g. food, blocks, toys)
	P	Helps a little while being dressed (e.g. extends arm to put in sleeve)
	P	Lifts cup to mouth with two hands to drink
	P	Picks up and eats finger foods
	P	Stands alone for 2 seconds or more
	P	Walks sideways holding on to furniture
	P	Lowers self from standing with control, not falling on bottom
Has	anyo	one noticed whether the child
Yes	No	
P		Has lost any previously obtained skills
P		Has inconsistent/no response when name is called
P		Rarely engages socially (e.g. smiling, eye contact)
P		Is more withdrawn or more difficult to comfort than other children
M		Is more interested in looking at objects than people's faces
P		Has any difficulty with feeding, chewing or swallowing
		URCE Fax: Fax:
		email: email:
peech 8	& Lang	consent to a referral being made to York Region Preschool guage Program and/or Early Intervention Services for my child
		Date: