

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

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	Is more withdrawn or more difficult to comfort than other children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: \_\_\_\_\_

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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