York Region
Community and Health Services
Early Intervention Services

ERIK
EARLY REFERRAL IDENTIFICATION KIT

MARKHAM STOUFFVILLE HOSPITAL CORPORATION
York Region Preschool Speech and Language Program

Referral for 18 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	
☐	⚐	Uses at least 20 words consistently even if not clear (e.g. labeling food, toys, people)
☐	⚐	Makes at least 4 different consonant sounds (e.g. p, b, m, n, d, g, w, h)
☐	⚐	Imitates words and gestures
☐	⚐	Responds with words or gestures to simple questions (e.g. "Where's teddy?", "What's that?")
☐	⚐	Understands the concepts of "in & out", "off & on"
☐	⚐	Points to three or more body parts when asked
☐	⚐	Points to familiar pictures using one finger
☐	⚐	Enjoys being read to and sharing simple books with you
☐	⚐	Demonstrates some pretend play with toys (e.g. gives teddy a drink, pretends a bowl is a hat)
☐	⚐	Walks alone (feet may have wide gait)
☐	⚐	Walks up and down stairs with assistance
☐	⚐	Climbs onto low step, table or stool
☐	⚐	Likes to retrieve and carry objects
☐	⚐	Takes off own socks and hat
☐	⚐	Stacks 3 blocks
☐	⚐	Brings spoon to mouth in attempts to self feed

Has anyone noticed whether the child

Yes	No	
⚐	☐	Has lost any previously obtained skills
⚐	☐	Has inconsistent/no response when name is called
☐	⚐	Tries to get your attention to show you what they are interested in
☐	⚐	Consistently points to what he / she wants when it is out of reach
☐	⚐	Looks for a toy when asked where it is or you point to it
⚐	☐	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⚐	☐	Is more withdrawn or more difficult to comfort than other children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
⚐	☐	When eating has sensitivity to different textures OR difficulty chewing or swallowing
⚐	☐	Lacks interest in toys or typically plays with them in an unusual way (e.g. lining up, spinning, opening/closing parts rather than using the toy as a whole)
⚐	☐	Is preoccupied with unusual interests or topics (e.g. light switches, doors, fans, trains)
⚐	☐	Shows an intense interest in letters or numbers and/or some ability to recognize untaught printed words
⚐	☐	Moves his/her fingers, hands or body in an odd or repetitive way
⚐	☐	STUTTERS: Parents report child "stutters" using repetitions of words (e.g."I I I") or syllables (e.g. "dadadaddy"),sound prolongations (e.g. "mmmommy) or blocks (e.g. "b----all")
⚐	☐	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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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

June 2013