

Speech/Language Referral

(To be completed by childcare staff if you are requesting a speech and language assessment)

Please describe your concerns regarding this child's communication and how this impacts his/her participation in your program: _____

Do you have concerns about this child's understanding of language? Yes No
Is this child able to follow directions? Yes No
Is this child able to answer questions? Yes No

Do you have concerns about this child's ability to express him/herself with words? Yes No
Does this child typically communicate using: Yes No
gestures and sounds Yes No
one or two words Yes No
complete sentences Yes No

Do you have concerns about this child's speech sounds? Yes No
Are you typically able to understand this child's speech? Yes No
Is this child able to take turns during play? Yes No
Does this child play appropriately with other children? Yes No
Do you have concerns regarding possible stuttering? Yes No
Does this child's voice seem hoarse, breathy or nasal? Yes No
Does this child drool? Yes No

Additional Comments:

Strategies attempted or in use to address concerns:

Parents' Concerns at Home:

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|---|
| Physiotherapy and/or Occupational Therapy Referral |
|---|

(To be completed by childcare staff if

requesting a physiotherapy or occupational therapy assessment)

Please describe your concerns about this child's function and how this impacts his/her participation in your program: _____

Is the child able to: (Check all that apply)

Use a ride-on toy , trike . Get on/off independently . Push with feet on pedals or on the ground .

Climb stairs independently with hand support without hand support .

Prefers to crawl up/down stairs .

Kick a ball to an intended target . Use either foot to kick .

Get arms ready to catch a ball . Attempt to catch by closing arms toward the body .

Catch ball successfully ___ times out of 5 trials.

Jump with both feet on the spot or bounce .

Dress/undress independently .

Use a toilet independently .

Finger feed . Use a spoon .

Does the child: (Check all that apply)

Use playground equipment or climbing equipment .

Trip or fall when walking .

Place their hands out to protect themselves when falling .

Avoid certain materials/textures (e.g., messy play, scratchy, rough) .

Avoid touch from others (e.g., hugs, hand-over-hand help) .

Cover their ears or react to certain noises .

Comment on noises you don't hear .

Avoid or prefer certain tastes or food textures (e.g., salty vs. sweet; crunchy vs. soft) .

Demonstrate a high activity level; fidget even when sitting .

Avoid activities involving movement (e.g., swings, slides) .

React negatively to or crave certain smells/odours .

Calm him/herself .

The child's movements appear: stiff wobbly clumsy

Strategies attempted or in use to address concerns:

Parents' Concerns at home: _____

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|----------------------------|
| General Information |
|----------------------------|

(To be completed by parents for all referrals)

Birth History

Were there any concerns during pregnancy or delivery? Yes No

If yes, describe: _____

Birth weight: _____ Premature Birth? Yes No If yes, how many weeks? _____

Were there any concerns with your baby's health after birth? Yes No If Yes, describe: _____

Was the baby in intensive care after birth? Yes No If yes, for how long? _____

Did your baby go home at the same time as you? Yes No. If not, how long did the baby remain in the hospital and why? _____

Child's Medical History

Has your child had any health problems?

Family Doctor: _____ Pediatrician _____

Does your child have asthma? Yes No Allergies? Yes No Please describe: _____

Is your child currently on medication? Yes No. Name of medication and purpose: _____

Has your child's vision been tested? Yes No. Date: _____ Results: _____

Has your child's hearing been tested? Yes No. Date: _____ Results: _____

Has your child had middle-ear infections? Yes No. If yes, how many? _____

Has your child seen an Ear, Nose and Throat Doctor? Yes No. If so when? _____

Does your child have tubes in his ears? Yes No. If yes, when were they placed? _____

Does your child have a history of feeding difficulties (e.g., difficulty breast or bottle feeding, difficulty transitioning to table foods, frequent choking, overstuffing his mouth)? Yes No. If yes, describe: _____

Does your child snore? Yes No.

Does your child have difficulty sleeping? Yes No.

Child's Developmental History (Milestones)**When did your child?**

Roll over (typically at 4-5 months) _____

Sit alone (6 months with support, 8 months with no support) _____

Eat solid food (6 months) _____

Did your child babble as an infant? Yes No

Speak first word (9 to 12 months) _____

Sleep through the night (9 to 12 months) _____

Pick up small items (12 months) _____

Crawl (10-12 months) _____

Walk alone (14 months) _____

Use 2-3 word phrases (24 to 30 months) _____

Toilet train (Start by 3 years, complete by 4 years) _____

Family Health History (List family members who have medical, educational or developmental challenges)

| Name | Relationship | Medical/Educational/Developmental Issues |
|------|--------------|--|
| | | |
| | | |
| | | |
| | | |

Other children in the home (Names and ages):

List anyone else who lives in the home (e.g., grandparents, aunt, etc.):

What languages are spoken in the home: _____

Other Agencies Involved with the family

| Agency | Contact Name | Reason | Status O/R/D |
|--------|--------------|--------|--------------|
| | | | |
| | | | |
| | | | |

O = Ongoing, R = Referred, D = Discharged

Has your child had a private assessment for speech physiotherapy occupational therapy .

Name of therapist and date of assessment: _____

Do you consent for the SPOT therapist to contact the private therapist? Yes No (Please initial)

Please attach a copy of the private assessment if available.

| |
|-----------------------------------|
| Parent Consent for Service |
|-----------------------------------|

What is the S.P.O.T. Service?

- A service to you and childcare providers in licensed childcare programs.
- An assessment service in one or more areas of development.
- Follow-up consultations to childcare providers at their request as they help your child develop.
- Suggestions for home use.

How are the assessments done?

- An appointment will be scheduled at the childcare location to observe your child with others and assess your child's development either in the group or individually in a separate, quiet space with fewer distractions.
- Following the assessment, a conference with parents and childcare providers is scheduled to share findings and discuss next steps.

How are the results of the assessments communicated?

- Information about your child's developmental skills and needs are openly shared with the childcare provider and parents in person, by phone and in written reports.
- It is understood that schedules and other events may prevent communicating with parents and childcare providers at the same time; childcare staff may receive information first.

Areas of my child's development to be assessed:

| <i>Initial next to the service(s) for which you are providing consent</i> | Initials |
|--|-----------------|
| Physiotherapy: Look at trunk control, balance, physical abilities in the classroom and/or on the playground (e.g., Climbing, jumping, hopping), muscle power, joint stiffness, walking and running. Joint range of motion and assessment of muscle tone involves the therapist moving the legs through the range of motion. | |
| Occupational Therapy: Look at play skills, social skills, fine motor development (e.g., scissor skills, pre-printing skills), attention to task, sensory processing skills, and self-help skills (e.g., dressing, feeding , toileting.) | |
| Speech Language Pathology: Look at voice, fluency (i.e., stuttering), resonance (i.e., movement of air through the nose), sound production, oral motor skills, expressive language, comprehension, and social communication. | |

I consent to:

- the assessment of my child's skills as requested above
- the verbal sharing of the results of my child's assessment with the childcare staff at a conference scheduled after the completion of the assessment
- the sharing of written report(s) and programs with the childcare staff

I understand that I am encouraged to attend the conference but, if I am unable to attend, the meeting may proceed in my absence.

I understand that I may call to clarify this process, ask questions or express concerns at any time by calling KidsAbility at 519-886-8886 and asking to speak with the SPOT Coordinator.

I understand that at any time I may withdraw my consent for all or part of a service or any communication about my child.

Printed name of Parent(s) or Legal Guardian

Witness

Signature of Parent(s) or Legal Guardian

Date

**Please fax or mail this form to the:
S.P.O.T. Coordinator,
KidsAbility
500 Hallmark Drive,
WATERLOO, Ontario N2K 3P5
Telephone No: 519-886-8886
Fax: 519-886-7292**

ORIG: Child Care file CC: faxed or mailed with S.P.O.T. Application, Parent

(SPOT Intake Sept 2011)