

Niagara Children's Centre Birth to School Start Speech-Language Pathology Referral Checklist – By 6 Months



Before Completing, please refer to:

- Niagara Children's Centre Birth to School Start Speech-Language Pathology Referral Checklist - Consent Form
- Guidelines for QCCN Referrals using the Niagara Children's Centre Birth to "School Start" Speech-Language Pathology Referral Checklist

If results of the Checklist indicate a referral is needed, please refer to:

- Guidelines for QCCN Referrals using the Niagara Children's Centre Birth to "School Start" Speech-Language Pathology Referral Checklist
- Niagara Children's Centre Birth to "School Start" Speech-Language Pathology Referral Form for QCCN

Child's Information

Child's First and Last Name: _____

Date of Birth (DD/MM/YYYY): ___/___/____

Checklist Completion Information

Date Checklist was completed (DD/MM/YYYY): ___/___/____ Child's Age at Checklist Completion: _____

Checklist Completed by: _____ Role/Agency: _____

Date Checklist was discussed with parent(s)/guardian(s) (DD/MM/YYYY): ___/___/____

Referral Information

- Is the child currently waiting for or receiving Speech-Language Pathology services at Niagara Children's Centre? Yes* No *If yes, **do not** refer
- Was a referral to Niagara Children's Centre made? Yes No

If yes, date referred (DD/MM/YYYY): ___/___/____

How to Score the Checklist

Each age category is divided into TWO Sections.

Section 1: Questions in this section represent skills that are expected "by" or "before" the age range listed.

- Answer each question with a YES or NO
- Make a referral if there are any "no" responses in this section

Section 2: Questions in this section refer to atypical communication concerns and behaviours that sometimes occur when a child is not developing communication as expected.

- Make a referral if there are any "yes" responses in this section

Section 1			
		YES	NO
1	Use different sounds or cries for different needs (<i>e.g. for hunger, tiredness, attention, etc</i>)	<input type="checkbox"/>	<input type="checkbox"/>
2	Turn toward the source of sounds	<input type="checkbox"/>	<input type="checkbox"/>
3	Startle in response to sudden, loud noises when awake	<input type="checkbox"/>	<input type="checkbox"/>
4	Watch your face as you talk	<input type="checkbox"/>	<input type="checkbox"/>
5	Smile and laugh in response to your smiles and laughs	<input type="checkbox"/>	<input type="checkbox"/>
6	Make noises such as coos, gurgles, and squeals	<input type="checkbox"/>	<input type="checkbox"/>
7	Try to make sounds when you make sounds (<i>does not need to copy the exact sound</i>)	<input type="checkbox"/>	<input type="checkbox"/>
		Refer for any “no” responses in Section 1	
Section 2			
		YES	NO
1	Have limited interest in people (<i>e.g. has limited smiling, laughing, making eye contact, or responses to a person’s speech/facial expressions/gesture; seems more interested in objects than people’s faces</i>)	<input type="checkbox"/>	<input type="checkbox"/>
2	No longer have social or communication skills they once did (<i>e.g. is no longer smiling and laughing, is no longer making noises</i>)	<input type="checkbox"/>	<input type="checkbox"/>
		Refer for any “yes” responses in Section 2	