

PRESCHOOL SPEECH AND LANGUAGE REGISTRATION FORM

Child's Information

Child's First Name:	Childs First Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other (specify):
Child's Date of Birth: Was your child born prematurely? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many weeks premature was your child at birth?
Postal Code: <i>(this is just used for geographic sorting)</i>	Are you a professional supporting a family? <input type="checkbox"/> Yes <input type="checkbox"/> No

Demographic Information

Child's Details

Child's First Legal Name:	Child Last Name:
Is the child a ward of the Children's Aid Society? <input type="checkbox"/> Yes <input type="checkbox"/> No	Child's First Language:
Childs Date of Birth:	Address (Including Unit Number):
Child's Gender:	
Child's Family doctor or nurse practitioner name:	Child's family doctor of nurse practitioner phone number:
Do you, the caregiver/legal guardian, require an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Who will be the person responsible for providing consent to receive service? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Family & Children's Services

Your Contact Details

Your first name:	Your last name:
Primary phone number:	Alternate phone number:
Which phone number can we leave a message? <input type="checkbox"/> Primary Phone <input type="checkbox"/> Alternate Phone <input type="checkbox"/> Neither	Best time to contact: <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Anytime
Email:	Relationship to Child: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> CAS
Same address as child? If no, write address: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Are you the primary contact? If no, enter Primary Contact details below <input type="checkbox"/> Yes <input type="checkbox"/> No	
First Name:	Last Name:
Primary Phone Number:	Alternate Phone Number:
Which phone number can we leave a message? <input type="checkbox"/> Primary Phone <input type="checkbox"/> Alternate Phone <input type="checkbox"/> Neither	Best time to contact: <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Anytime
Email:	Relationship to Child <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> CAS
Same Address as child? If no, write address: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Is there a secondary contact? If Yes, enter secondary details below <input type="checkbox"/> Yes <input type="checkbox"/> No	
First Name:	Last Name:
Primary Phone Number:	Alternate Phone Number:
Which phone number can we leave a message? <input type="checkbox"/> Primary Phone <input type="checkbox"/> Alternate Phone <input type="checkbox"/> Neither	Best time to contact: <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Anytime
Email:	Relationship to Child <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> CAS
Same Address as child? If no, write address: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Do you have concerns: (Select all that apply) <input type="checkbox"/> with your child's speech and language development? <input type="checkbox"/> that your child may be stuttering? <input type="checkbox"/> with your child's voice? <input type="checkbox"/> that your child may be showing signs of autism? <input type="checkbox"/> with your child's behaviour? <input type="checkbox"/> with your child's feeding (diet)? <input type="checkbox"/> with your child's hearing?	
How many ear infections has your child had in the last year?	What was the result of your child's newborn infant hearing screening? <input type="checkbox"/> Pass <input type="checkbox"/> Fail
Was your child's hearing tested again after the newborn infant hearing screen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tell us in your own words what your concerns are:	

Family Information

<p>Would any of the following make it difficult for you to bring your child to treatment? (check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lack of English or French <input type="checkbox"/> Lack of childcare <input type="checkbox"/> Lack of transportation <input type="checkbox"/> Other <p>If other, please describe:</p>	<p>Do either parents or siblings present with any of the following? (check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Stuttering <input type="checkbox"/> Hearing loss <input type="checkbox"/> Developmental delay <input type="checkbox"/> Problems with speech and/or language <input type="checkbox"/> Attention Difficulties <input type="checkbox"/> Autism Spectrum Disorder (ASD) <input type="checkbox"/> Problems-Learning/reading/writing <input type="checkbox"/> mental health concerns <input type="checkbox"/> Other <p>If other, please describe:</p>
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Previous Services Received

<p>Has your child been seen, or is waiting to be seen, by any of these services or programs? (check all that apply)</p>	
<ul style="list-style-type: none"> <input type="checkbox"/> Kids Inclusive <input type="checkbox"/> CHEO <input type="checkbox"/> Speech & Language Assessment <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Ophthalmology (eye tests by a doctor) <input type="checkbox"/> Audiology (hearing) <input type="checkbox"/> Ear, Nose and Throat Specialist (ENT) <input type="checkbox"/> Psychological or Developmental Assessment <input type="checkbox"/> Coordinated Service Planning <input type="checkbox"/> Infant and Child Development Program <input type="checkbox"/> Healthy Babies Healthy Children <input type="checkbox"/> Ontario Autism Program <input type="checkbox"/> Other 	<p>If other, describe: Where?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Preschool Speech & Language Program <input type="checkbox"/> Private Speech Language Provider <input type="checkbox"/> Other (eg: out-of-province service)

Child's Birth and Medical History

Were there any medical problems or worries when the Mother was pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:	
Did the Mother take any medications while she was pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:	
How long was the pregnancy (weeks)	What did the baby weigh at birth?
Were there any problems or unusual worries in the first week of your child's life? (early feeding, latching, other) <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child had any history of significant medical problems? <input type="checkbox"/> Yes <input type="checkbox"/> No

Child's Development

Motor Development

At what age did your child do these things?		
Sit alone:	Crawl:	Walk Alone:

Motor Development

At what age did your child do these things?	
Say single words:	Put words together (eg: "go bye bye, more juice")
How does your child tell you what he/she wants? (check all that apply)	
<input type="checkbox"/> Crying <input type="checkbox"/> Looking at objects <input type="checkbox"/> Pointing at what he/she wants <input type="checkbox"/> Making a gesture <input type="checkbox"/> Making sounds/grunting	<input type="checkbox"/> Pulling you to what he/she wants <input type="checkbox"/> Saying single words <input type="checkbox"/> Saying 2 or 3 words together <input type="checkbox"/> Talking in sentences

Play Development

<p>What kind of activities does your child like to do?</p>
<p>Does your child have opportunities to play with other children his/her age? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe activities (eg. sports, daycare, playing with friends):</p>

Your Child in the Community

<p>Is your child attending any of the following? (check all that apply)</p> <p><input type="checkbox"/> Childcare Centre <input type="checkbox"/> Nursery school <input type="checkbox"/> Home Daycare <input type="checkbox"/> At home with parent/caregiver <input type="checkbox"/> Kindergarten <input type="checkbox"/> EarlyOn Child and Family Centre</p>	<p>Please list childcare centres:</p>
	<p>Please list nursery schools:</p>
	<p>Please list child's school:</p>
<p>Where did you hear about Surrey Place?</p> <p><input type="checkbox"/> School <input type="checkbox"/> EarlyOn <input type="checkbox"/> Primary Care Provider <input type="checkbox"/> Family <input type="checkbox"/> Family Services <input type="checkbox"/> Online (google, etc) <input type="checkbox"/> Daycare <input type="checkbox"/> Other</p>	

Consents

To continue with this referral, you **MUST AGREE** to the Surrey Place Privacy Statement and Consent. If you do not agree, your child will not be referred.

Privacy Statement

- The information collected in this questionnaire will be used to process your referral with Surrey Place's Preschool Speech and Language Program. It may also be used to aggregate statistical analysis and reporting. This system is hosted by an external service provider called Care dove under contract with Surrey Place. Care dove protects all personal health information (PHI). Only authorized Surrey Place staff have access to this system.
- Please call Surrey Place at 416-925-5141 and connect with our Privacy Officer, Felix Camposano, if you have concerns about data privacy. You can also contact us at any time to withdraw your consent.

Consent to Data Sharing

- Surrey Place will share the information in this questionnaire with partner agencies so they can provide the services your child needs. Surrey Place is comprised of 13 partner agencies, but your information will only be shared with the agency or agencies that provide services for your child and family. The agency providing services for your child and family will store your personal information securely in their local clinic database. Please see a complete listing of agencies that deliver Surrey Place HCD services.
- If you have any questions about how your personal information will be handled, please call Surrey Place at 416-925-5141 and connect with our Privacy Officer, Felix Camposano. You can also contact us at any time to limit or withdraw your consent.

Consent to Store Personal Health Information

- The Preschool Speech and Language Program is part of Ontario's Healthy Child Development Program which utilizes the Healthy Child Development - Integrated Services for Children Information System (HCD-ISCIS) to store client information. When you access the Preschool Speech and Language Program, your information will be stored in the HCD-ISCIS database. This information includes your contact information; names and birthdates of your family members and any other HCD programs (Infant Hearing, Blind Low Vision Early Intervention) you are accessing. Your information is only accessed by HCD service providers when they provide services to your family and only authorized Surrey Place staff have access to this system.
- Your information is protected by privacy legislation, so it is always kept secure. Only the program's overall statistics are public. If you need more information you can call Surrey Place at 416-925-5141 and connect with our Privacy Officer, Felix Camposano.

Please send the completed form to Children & Youth Intake by confidential fax at 416-925-3402.

Sign here to confirm that you agree with the
Surrey Place Privacy Statement and Consent: _____