

**ASSISTIVE TECHNOLOGY
EVALUATION REFERRAL
FORM**

To be completed only when an assistive technology evaluation has been recommended. If the evaluation being requested is due to problems in the area of communication, include the Parent Home Data Questionnaire with the two-page AT Evaluation Referral Form.

**Brownsville Independent School District
Assistive Technology Evaluation Referral Form**

Student: _____ D.O.B. _____ ID#: _____
Medical Diagnosis (if applicable): _____ School: _____
Teacher: _____ Grade: _____ Room# _____ Date: _____

CURRENT EDUCATIONAL PLACEMENT:

- PPCD RESOURCE CMC DYSLEXIA
 LIFESKILLS INCLUSION HOMEBUND OTHER _____

Disability (Check all that apply):

- Auditory Impairment Autism Deaf-Blind
 Emotional Disturbance Learning Disability Mental Retardation
 Other Health Impairment Non-Categorical Orthopedic Impairment
 Visual Impairment Speech Impairment Traumatic Brain Injury

FUNCTIONAL DEVELOPMENTAL SKILL LEVELS:

- 0-3 years 3-5 years K-2nd grade
 3rd – 5th grade 6th – 8th grade 9th - 12th grade

CURRENT SERVICES:

- Speech Therapy Physical Therapy VI Specialist Parent Training
 Occupational Therapy Counseling/BI AI Specialist APE

HEARING: ___ WNL ___ wears hearing aids **VISION:** ___ WNL ___ wears glasses

Language/Communication

___ Nonverbal ___ Verbal (intelligibility: ___ good ___ fair ___ poor)

Is there a discrepancy between receptive and expressive abilities? Yes No

If yes, describe further: _____

___ **Uses a communication system (Check all that apply)**

- Sign language Vocalizations Picture Symbol Board
 Speech and sign together Picture Cues PECS
 Gestures Written Messages Voice-Output

Written Expression

Current writing ability: (Check all that apply)

- Uses regular pencil Can copy words Writes legibly
 Uses adapted pencil Can copy from board Writes illegibly
 Can print name Uses regular paper Writing is slow
 Can print a few words Uses special paper Fatigues when writing
 Can write cursive Uses Braille Uses word processor

Student has difficulty with: (Check all that apply)

- writing single words writing essays planning content
 writing phrases getting started on a story sequencing information
 writing sentences generating ideas using a variety of vocabulary
 writing paragraphs adding information to a topic summarizing information

Current keyboarding ability: (Check all that apply)

- Does not type Uses adapted keyboard _____
 Uses a portable word processor for typing Can perform 10 finger touch typing (wpm)
 Types with one finger Uses switch to access computer
 Requires wrist or hand support to write Uses mouse alternative _____

Reading:

The student reads at _____ grade level orally.

The student reads at _____ grade level silently.

Math:

Student has difficulty with: (Check all that apply)

- Sequencing numbers
- Understanding meaning of numbers
- Remembering simple math facts
- Solving story problems
- Understanding math vocabulary
- Understanding place value
- Understanding measurement
- Graphing

Mobility:

- walks independently
- walks with assistance
- uses walker
- uses wheelchair (_____ self-propelled _____ with assistance _____ motorized)
- appropriate for classroom setting
- noncompliant
- very passive in classroom setting
- inadequate attention span
- adequate attention span for classroom tasks
- easily frustrated

1. List up to three IEP objectives that are not being mastered which might improve with the use of assistive technology:

2. List modifications, strategies, equipment and/or materials which have been tried for this student to meet IEP objectives:

3. Is a computer available for student use? _____ regular ed. classroom _____ special ed. classroom
_____ computer lab _____ home

4. Summary of parent concerns: _____

Please attach a copy of middle and high school student's current class schedule.

Person (s) completing form: _____

PARENT HOME DATA ASSISTIVE TECHNOLOGY COMMUNICATION QUESTIONNAIRE

This form will be used to gather the necessary information to customize a communication system for your child. Please answer all questions if possible.

Name: _____ Birth date: _____
Home Phone: _____ Mother's Work #: _____ Fathers Work# _____

Does your child attend a child care facility after school? YES _____ NO _____

FAMILY INFORMATION:

Names of relatives and friends with whom your child interacts on a regular basis:

Questions you would like answered by this assessment are: _____

FAVORITE ACTIVITIES

T.V. (Name of show (s) & Characters)

Toys: _____

Community Outings: _____

Reading (Name of Books)

Arts & Crafts: _____

Special interest: (Circle) Swings Puzzle Camping Fishing

Other (specify) _____

Favorite Food & Drinks: _____

Daily Home Routine: (Give brief description of a typical day's activities):

Routinely Scheduled After School Activities:

CONVERSATIONAL NEEDS: List 6 things you would like you child to be able to communicate:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

YOUR CHILD'S DISLIKES AND/OR FEARS:

Form Completed By: _____ Date: _____