Assistive Technology Referral Form

Date: _____ Person Requesting Referral: _____

Student's Name:_____Date of Birth:_____ Age: _____

School:_____ Grade: _____

School Contact:_____ Phone: _____

Parent/Caregiver:_____ Phone:_____

Disability (Check all that apply)

□ Speech/Language Impairment
□ Cognitive Impairment
□ Traumatic Brain Injury
□ Emotional Impairment
□ Physically Impairment
□ Otherwise Health Impairment
□ Autism Spectrum Disorder
□ Specific Learning Disability
□ Hearing Impairment
□ Visually Impairment
□Early Childhood Developmental Delay
□ Deaf-Blindness
□ Severe Multiple Impairment

Classroom Setting

□ General Education Classroom
□ Co-Taught General Education Classroom
□ Resource Room
□ Self-Contained
□ Home

Current Service Provided to Student

□ Occupational Therapy
□ Physical Therapy
□ Speech and Language
□ Social Work
□ Teacher Consultant
□ Other _____

Medical Considerations

Please describe what assistive technologies are currently being used or have previously been tried.

Assistive Technology	Length of Trial	Outcomes

Referral Question

What task(s) does the student need to do that is currently difficult or impossible directly related to the students IEP goal, for which assistive technology may be an option? (Describe in detail)

Please check the area(s) of concern

□ Seating, Positioning and Mobility
□ Communication
□ Computer Access
□ Motor Aspects of Writing
□ Composition of Written Material
□ Reading
□ Mathematics
□ Organization
□ Recreation and Leisure
□ Vision
□ Hearing
□ Daily Living

Team Meeting will be held: _____ Person Completing Form: _____