



Assistive Technology (OATS) Department

Student Name: _____

Date of Request: _____

Please choose all appropriate services, fill in necessary information and include requested documentation.

To assist Monroe One in fulfilling your request, please indicate the reason for referral and any additional information that will help us provide services:

Assistive Technology Evaluation (By sending the request, Monroe One assumes consent has been received)

Reason for Evaluation and desired outcome: _____

Areas of concern:

- Reading
Writing
Math

- Communication
Physical Access
Organization in the area of _____

CSE Date/Time: _____ OR not scheduled

Consultation:

Frequency (number of hours per year): _____

Equipment/Software/Hardware Purchase: For Monroe One program students ONLY

Please indicate specifically what is to be purchased: _____

Documentation Requested (if available):

- IEP/504 (services must match the request)
Previous Speech/Language Evaluations
Current Psychological Evaluation
Previous AT Evaluation
Previous Vision Evaluation
Previous OT/PT Evaluation
Cross Contract (if a non-component district)

Send cover sheet, request forms and requested documentation to ltinerant@boces.monroe.edu

OFFICE OF SPECIAL EDUCATION AND STUDENT SERVICES