Assistive Technology Referral Form

Student Name _____ School: _____

Date of Birth: _____ Age: _____ Sex: _____ Grade:_____

Parent/Guardian: _____ Home Phone _____

Address: _____ Work Phone _____

_____ E-mail Address: _____

_____ _____

Exceptionality: _____ Related Services: _____

Teacher: _____ Paraprofessional: _____

_____ Minutes per week in Regular Ed. _____ Minutes per week in Sp.Ed.

Requested by: _____ Phone: _____

I. Area(s) of Concern

a. Activities of Daily Living
b. Communication
c. Composing Written Material
d. Computer Access
e. Environmental Control
f. Hearing
g. Learning/Studying
h. Math
i. Mechanics of Writing
j. Mobility
k. Positioning and Seating
l. Reading
m. Recreation and Leisure
n. Vision

Other _____

II. Describe the student's current level of performance in this area. What is he/she able to do? What tasks are difficult or impossible because of the disability?

III. In what environment does the student experience this difficulty?

IV. What has already been tried to help with this problem?

a. What helped? How did the student's performance change as a result of this strategy?

b. What didn't work? Why not?

V. What technology does the student currently use?