

ASSISTIVE TECHNOLOGY ASSESSMENT REFERRAL

ASSESSMENT: The purpose of this assessment/evaluation is the development or revision of an IEP. The District assumes the responsibility for obtaining parent consent for this assessment (IEP Form 22A) and scheduling an IEP meeting. **All signed assessment plans must be received by ATC in a timely manner and notice of IEP meeting must include ATC staff.**

- Attached Assessment Plan
- Attached Release of Information

Special Education Principal or District Director Name: _____

 Signature Date signed Phone Number

Date:		
Student:		Age/Grade:
District of Residence:	School:	Primary Placement: - Circle one: Reg. Ed. RSP SDC
DOB:		Program: - Circle one District SCOE _____
Low Incidence Eligibility - Circle one: VI		DHH Severe OI
List prior attempted or implemented interventions and results of implementation.		
1.		
2.		
3.		

Service & Assessment Team:

TEAM

COORDINATOR: _____

Name of Contact/Referring Person Phone Number Email/Alt. Phone

Who can be referred for an AT assessment:

Students who have either a primary or secondary Low Incidence eligibility criteria on their IEPs: Visually Impaired; Blind; Deaf; Hard of Hearing; Deaf/Blind; Orthopedically Impaired (Severe) or students who have severe communication needs: Nonverbal and/or Unintelligible Speech.

Participants	Name	Email	Phone
Parent			
Parent			
Teacher			
Admin., Counselor			
Speech/Language			
OT/PT			
Vision Specialist			
Hearing Specialist			
Regional Center			
Other			

REFERRAL QUESTIONS

1. What task(s) does the student need to do that is currently difficult, and for which assistive technology may be an option?

2. What outcomes do you want from this referral?

3. What specific equipment/software do you want to consider?

Disability (Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Deaf-Blindness | <input type="checkbox"/> Deafness | <input type="checkbox"/> Specific Learning Disability |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Other Health Impairment | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Emotional Disturbance | <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Orthopedic Impairment | |

Based on the referral question, check all areas that apply:

- | | |
|---|---|
| <input type="checkbox"/> Motor Aspects of Writing | <input type="checkbox"/> Fine Motor – Computer/Device |
| <input type="checkbox"/> Composing Written Material | <input type="checkbox"/> Communication |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Learning/Studying |
| <input type="checkbox"/> Math | <input type="checkbox"/> Vision |

Describe how these areas affect the student's learning and school performance:

Diagnosis:

Vision:

Hearing:

Fine Motor:

Cognitive Skills:

Academic Skills:

Reading Abilities:

Challenges:

Writing Abilities:

Challenges:

Spelling Abilities:

Challenges:

Math Abilities:

Challenges:

Current Computer/Technology Skills and Equipment:

Communication Skills

Expressive

Receptive

Social/Behavioral Skills: positive and negative:

Student's strengths, learning style, coping strategies, or interests:

Other Issues, Comments, Information that the team should consider:

Does student fatigue easily, or experience a change in performance at different times of the day?

