BelieveAbility

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Assistive Technology – Referral Information Form

Student's Name _____ Date of Birth _____ Gender __

School _____ Grade _____

School Address _____ School Phone # _____

_____ District _____

School Contact _____ Phone # _____
(Case Carrier)

Email _____

Parent/Guardian _____ Home Phone # _____

Home Address _____ Work Phone # _____

_____ Email _____

Student's Primary Language _____ Secondary Language _____

Purpose of Referral/Consultation

☐Assessment* ☐Setup/Training ☐Technical Support ☐Other _____

*Assessment plan required for assessment

Disability (check all that apply)

☐Speech/Language ☐Significant Developmental Delay ☐Specific Learning Disability
☐Cognitive Disability ☐Other Health Impairment ☐Emotional/Behavioral Disability
☐Traumatic Brain Injury ☐Autism ☐ Vision Impairment ☐Hearing Impairment
☐Orthopedic Impairment – Type _____
☐Other _____

Assistive Technology - currently used, tried or to be considered

_____

Referral Question ***(required)***

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

_____

_____

_____

Requested by Title Date Phone #

Date report requested for IEP _____

Confidential