

Assistive Technology Team Referral

Instructions: Send 1) a copy of the student's **current IEP**, 2) completed referral form with parent signature, and 3) any relevant reports (hospital, clinic, specialist) to team leader **Anja Kintsch at the Ed. Center, Dept. of Sp. Ed.**. As soon as all paperwork is received, an evaluation can be scheduled. Evaluations usually take about an hour and a half and consist of consultation with school staff and parents followed by observation of the student.

Student name:

Date of Birth:

Grade:

Please describe the student's disability and any relevant medical conditions (including vision and hearing limitations):

Please describe what you hope the student will be able to do as a result of this evaluation:

I have read this completed referral form and give my permission for an Assistive Technology Team evaluation.

Parent signature:

Date:

Parent address, phone, and e-mail:

School:

Phone:

Teacher:

E-mail:

Anja Kintsch, Assistive Technology Team Leader
303/447-5001 ext. 8953#
e-mail anja.kintsch@bvsd.org

Date received
by ATTeam:

Learning

Writing

Concerns with Writing (Check all that apply):

- Writing speed
- Legibility
- Spelling

Preferred Writing Style:

- Print
- Cursive
- Keyboarding
- Dictation

Reading

Concerns with Reading skills (Check all that apply):

- Letter identification
- Sound-Symbol correspondence
- Text comprehension
- Reading speed

Math

Concerns with Math skills:

- Number concepts
- Computations
- Abstract thinking
- Memorization of facts

Study Skills

Concerns with Study skills

- Organization
- Homework completion
- Note taking

Comments:

Computer Access

Home:

- Macintosh
- Windows
- Other

School:

- Macintosh
- Windows
- Other

What things have been or are being done to help the student overcome writing difficulties?

Computer keyboard access

- ___ 10 fingers
- ___ 1 finger (index)
- ___ 2 fingers (index on both hands)
- ___ thumb, index and second on both hands
- ___ one hand (___R ___L)
- ___ Other:

Communication

Student currently communicates via:

Voice/speech

Quality: clear sometimes difficult to understand usually difficult to understand

Vocalizations

Describe:

Sign language

Gestures

Describe:

Pointing

Eye gaze

Communication book

Photographs Drawings Objects Words

High tech. System

Which one? _____

Clear way to indicate "Yes" and "No"?

Describe:

- Is it difficult for familiar people to understand the student's basic needs?
 Yes No Sometimes

- Does the student understand more than he/she is able to express?
 Yes No Sometimes

If yes, please explain:

What communication methods have been tried?

What would you like to see this student able to do?

Physical Access

Does the student have physical limitations that impact learning ability?

Yes No

If yes, please check any of the following that apply:

- Uses a wheelchair Does not have accurate reach
 Electric Manual Does not have accurate point
 Independent Needs assist Cannot isolate finger movements
 Dyspraxia (difficulty motor planning) Tremors
 Motor impairments interfere with handwriting or typing (please describe):

Other (please describe):

What other things have been tried or are being used to help the student overcome physical limitations in order to effectively learn and communicate?

School Specialists:

NAME:

SIGNATURE:

Special education teacher:	
Speech therapist:	
Occupational therapist:	
Physical therapist:	
Classroom teacher(s):	
Other:	

To be Completed by Parents

General

What skills do you believe are important for your child to develop?

Are there significant factors about your child's strengths, learning style, coping strategies, or interests that the team should consider?

Are there any other significant factors about your child that the team should consider?

Does your children receive outside therapies? (Check all that apply)

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Speech/Language | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Psychologist |
| | <input type="checkbox"/> Other |