Parent Consent Date _____

Assistive Technology Referral Form

Region 3 Special Education Coop.

Student Name	Age	Birth Date	Referral Date
School	School Phone		District
Classroom Teacher	Grade		
Parent/Guardian	Home phone		
District Coordinator	Phone	Fax	Email

Medical Diagnosis

Special Services Received:
OT PT SLP VI HI Other_____

Reason(s) for Referral
____Computer-assisted Instruction ____Augmentative Communication ____Other_____

1. Briefly describe the Student's special needs.

2. Briefly describe the Student's current abilities.

3. Briefly describe what the student needs to be able to do.

4. How will Assistive Technology help the student accomplish his/her IEP goals?

5. What accommodations and/or modifications have been tried with this student?

6. What technology is currently available to the student?

District Coordinator approval (if necessary)_____Date_____

Director approval (if necessary)_____Date_____

Please make additional comments on the back
Return completed form to Brian Dowd, Assistive Technologist
bdowd@altonschools.org