ACTS

ASSISTIVE TECHNOLOGY (AT) STUDENT REFERRAL FORM

Date of Referral: Form Completed by:

School: Telephone:

Student's Name: _____ Birth Date:

Parent: Telephone: (Home)

Email: (Work)

Street: _____

City: _____ State: Zip: _____

School: _____

Address:_____

School Phone: _____

Regular Education θ Grade _____ Room Number _____

Resource ☐

Percent of Mainstreamed Classes _____

Number of Class Periods in Resource _____

Resource Support for the following classes: _____

_____

_____

Special Day Class ☐

Preschool ☐ Primary (K-3) ☐ Intermediate ☐ 4th-6th

Middle School ☐ High School ☐ Transition ☐

Learning Challenged ☐ Severely Challenged ☐

Orthopaedically Challenged ☐ Other ☐ _____

Site Team Members	Name	Telephone	Email
Case Manager:			
Teacher:			
Speech/Lang. Path.			

Name Telephone: Email

O.T.

P.T.

Program Specialist:

Vision Specialist:

Other:

Pertinent History

Medical Diagnosis: (Type; Degree; Severity)_____
(Check all that apply.)

- ☐ Cerebral Palsy
- ☐ Degenerative Neurological Disease
- ☐ Acquired Neurological Injury (Head Trauma)
- ☐ Dyslexia
- ☐ Pervasive Develpmental Disability
- ☐ Attention-Deficit Disorder/ADHD
- ☐ Autism
- ☐ Nonverbal learning Disability
- ☐ Learning Difference
- ☐ Cognitive Disability

Other Challenges not specified above:_____
_____

Speech/Language/Communication Status: (Describe present abilities/limitations)_____

_____

_____

Educational Functioning

Reading Grade Level: _____

Writing Grade Level: _____

Math Grade Level: _____

Learning Challenges:

Is the student falling significantly below in one or more subjects? Yes θ No θ

If yes, what subjects are causing difficulty?

_____

Motor Abilities

	Yes	No
Is the student ambulatory?	◯	◯

Describe the physical abilities the student has:

1)	Can use traditional writing tools (paper, pencil)?	◯	◯
2)	Can use a standard keyboard with one or more digits?	◯	◯
3)	Can use an expanded keyboard or touch screen to access the computer?	◯	◯
4)	Can use a single switch to access the computer/scanning? Describe:	◯	◯

5) Describe specific challenges related to motor abilities which impact student's ability to complete work accurately, legibly, and within the time allotted in class?

Sensory Abilities

1)	Does the student have a hearing impairment?	Yes ◯	No ◯
2)	When was the last hearing test?		
3)	Does the student have any visual acuity problems?	Yes ◯	No ◯
4)	Has the student had a visual assessment?	Yes ◯	No ◯
5)	What is the visual diagnosis?		

6) Does the student have tactile-kinesthetic disorder? Yes ◯ No ◯

7) Describe specific challenges related to sensory limitations, which impact student's ability to listen, read, and process in class?

Behavioral

1) Does the student have any behavioral problems? Yes ◯ No ◯

If yes, please describe:

2) Does the student have a short attention span and distractibility? Yes ◯ No ◯

Current Educational Modifications

What modifications/adaptations are currently employed for this student in order to permit educational participation?

2) What assistive technology is currently in place? What hardware/software and peripherals are used? When are they used?

Needs & Limitations

1) What are the limitations of the modifications/adaptations currently used?

2) What are the limitations of the student, which impact on education? (motor, sensory, learning challenges, etc.)

3) What are the limitations related specifically to the instructional context? (e.g. student moves from class to class and does not have access to a writing tool in every setting).

Services Needed

What is the primary reason you are seeking assistive technology services?

Please indicate the services needed below:

- ☐ Assistive Technology Assessment
- ☐ Assistive Technology Consultation
- ☐ AT Instructional Strategies/Plan
- ☐ Staff Training
- ☐ Technical Assistance
- ☐ Other (Please describe.)

Comments:

Funding for Technology: **Check all that apply**

4	**SOURCES OF FUNDING**	**Contact**	**Address**	**Phone**
	California Children's Service MTU Active			
	Medi-Cal Active MR #			
	Private Health Insurance Carrier:			
	Durable Medical Coverage on Med. Insurance			
	Low Incidence Eligibility/School District IDEA-R Assistive Technology Regs.			

Authorized Services: (To be completed by Program Specialist)

NOTE: ***If you are requesting an assessment, please send the most recent IEP, all psychological evaluation, speech/language, occupational/physical therapy evaluations/progress reports, and any other pertinent records pertaining to the Assistive Technology Evaluation to the Program Specialist. The Program Specialist will review the referral form and records and contact you to initiate service. Once approved, the parent must sign an Assessment Plan before services can be initiated.***

Records Submitted with this Referral Packet

I.E.P. ☐ Dated _____

1. Were AT Services Specified on the IEP Yes ☐ No ☐
1. If Yes, how are they listed on the I.E.P. _____

Psychological Evaluation ☐ Dated _____

Speech/Language Evaluation ☐ Dated _____

Speech/Language Progress ☐ Dated _____

Occupational Therapy Eval./Progress ☐ Dated _____

Physical Therapy Eval./Progress ☐ Dated _____

Specialized Learning Assessments ☐ Dated_____