

Virginia AT Referral Form

Student's Name _____ Date of Birth _____

Age _____ Grade _____

School _____

School Contact Person _____ Phone _____

E-mail _____

Person/s Completing Referral _____ Date _____

Parent(s) Name _____ Phone _____

E-Mail _____

Address _____

Have you completed an AT consideration guide? _____ Yes _____ No

Summarize the student's strengths and abilities:

Summarize the student's challenges and difficulties:

Referral Question

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

Environment

<input type="checkbox"/> General Education Teacher:	<input type="checkbox"/> Resource Room Teacher:	<input type="checkbox"/> Self-contained Teacher:
<input type="checkbox"/> Home	<input type="checkbox"/> Other _____	

Current Service Providers

<input type="checkbox"/> Occupational Therapy Name:	<input type="checkbox"/> Physical Therapy Name:	<input type="checkbox"/> Speech/Language Name:
<input type="checkbox"/> Other(s) _____		

Assistive Technology Currently Used (Check all that apply.)

- | | |
|----------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Accessible Instructional Materials (AIM) |
| <input type="checkbox"/> Low tech Writing Aids | <input type="checkbox"/> Large Print |
| <input type="checkbox"/> Low tech Reading Aids | <input type="checkbox"/> Electronic Text |
| <input type="checkbox"/> Visual Supports | <input type="checkbox"/> Braille |
| <input type="checkbox"/> Low tech Vision Aids | <input type="checkbox"/> Audio Text |
| <input type="checkbox"/> Communication supports | <input type="checkbox"/> Amplification System |
| <input type="checkbox"/> Math Supports | <input type="checkbox"/> Environmental Control Unit/EADL |
| <input type="checkbox"/> Word processing | <input type="checkbox"/> Positioning/Mobility Devices |
| <input type="checkbox"/> Specialized writing software | |
| <input type="checkbox"/> Adapted instructional materials | |

Describe: _____

Assistive Technology Tried

Please list any other assistive technology tried within the previous 12 months, including length of trial, and outcome (how did it work or why it didn't work.)

Device	Dates of Trial Period	Outcome

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Attach completed AT consideration guide to this referral