**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**

|  |  |  |
| --- | --- | --- |
| ❒ General Education Teacher: | ❒ Resource RoomTeacher: | ❒ Self-contained Teacher: |
| ❒ Home | ❒ Other  |

**Current Service Providers**

|  |  |  |
| --- | --- | --- |
| ❒ Occupational TherapyName: | ❒ Physical TherapyName: | ❒ Speech/Language Name: |
| ❒ Other(s)  |

**Assistive Technology Currently Used** (Check all that apply.)

☐None

☐Low tech Writing Aids

☐Low tech Reading Aids

☐Visual Supports

☐Low tech Vision Aids

☐Communication supports

☐Math Supports

☐Word processing

☐Specialized writing software

☐Adapted instructional materials

☐Accessible Instructional Materials (AIM)

 ☐Large Print

 ☐Electronic Text

 ☐Braille

 ☐Audio Text

☐Amplification System

|  |
| --- |
| ☐Environmental Control Unit/EADL |
| ☐Positioning/Mobility Devices  |

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** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Attach completed AT consideration guide to this referral**