

**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

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