

Jefferson Parish Public School System
Assistive Technology Referral Form

Student: _____ School: _____

DOB: _____ Age: _____ Grade: _____ Gender: _____

Parent(s): _____ Phone: _____

Address: _____

Exceptionality: _____ Teacher: _____

Related Service Providers: _____

Time spent in regular education class each day: _____

Time spent in special education class each day: _____

Referred By: _____ Relationship to Student: _____

Pertinent medical diagnosis/diagnoses (sensory impairment, cerebral palsy, seizures, etc.):

Area of Assessment Needed:

- _____ Communication
- _____ Computer Access
- _____ Learning/Studying
- _____ Math
- _____ Mechanics of Writing (attach samples of writing)
- _____ Reading
- _____ Written Composition (attach samples of writing)
- _____ Other: _____

Reason for Referral:

1. What task does the student need to accomplish?

2. What is the student's current level of performance on this task?

3. How is the student's disability affecting his/her performance?

4. In which environment(s) does this task need to be done?

5. Are there environmental concerns or other issues of concern?

6. What classroom modifications and adaptations have been tried to address this concern?

7. What was the outcome of the classroom modifications?

8. List any assistive technology that has been used or is presently being used (i.e. switch, communication device, alternate keyboard, etc.) and indicate why the AT is not successful.

9. Are there specific tools or strategies that someone on the team thinks should be considered?

Any additional pertinent information:

Send the following to the Assistive Technology Coordinator

- **AT Consideration checklist (AT1/ABIT1)**
- **AT Screening Form (AT3/ABIT3)**
- **Handwriting samples (if applicable) and/or additional information**
- **AT Referral Form (AT4/ABIT4)**

Signature

Date Signed