

Assistive Technology Questionnaire

Name of Student using Assistive Technology: _____ Date _____

Equipment or device being considered: _____

Person completing this form _____ Position _____

Please circle the number that represents your feelings as to how effective the equipment item above would be for this individual.

<u>Technology Characteristics</u>	Not Effective			Very Effective	
1. Reliability/dependability	1	2	3	4	5
2. Accomplishes its purpose	1	2	3	4	5
3. Can be used independently by the student	1	2	3	4	5
4. Is compatible with existing technology	1	2	3	4	5
5. Appropriate to user's visual abilities	1	2	3	4	5
6. Appropriate to user's physical abilities	1	2	3	4	5
7. Ease of use	1	2	3	4	5
8. Adequate staff support	1	2	3	4	5

Contextual Match

1. Socially appropriate/acceptable	1	2	3	4	5
2. Can be used well in this classroom/location	1	2	3	4	5
3. Avoids conflicts with noise, lighting, time, etc.	1	2	3	4	5
4. Space is available	1	2	3	4	5
5. Ease of portability across settings	1	2	3	4	5
6. Will be appropriate over time, (1-3 years)	1	2	3	4	5

Technology Benefits the Student

Not Beneficial

Very Beneficial

Student makes frequency use of the device	1	2	3	4	5
Device produced improved academic performance	1	2	3	4	5
Device produced higher percentage of completed assignments	1	2	3	4	5
User enjoys working with the device in class	1	2	3	4	5
User benefits from using the device in class	1	2	3	4	5
User needs the device to benefit from current educational program	1	2	3	4	5
Likelihood user will continue to use the device	1	2	3	4	5
Current technology is an improvement over previous technology employed	1	2	3	4	5

Additional Comments: _____
