

Date Rec'd: _____

**School District's Name
Special Education Services
Assistive Technology Team
UATT**

Initial Referral Form

Student: _____ DOB: ___/___/___ Date: _____
Referral Person: _____ Phone: _____
School: _____ Grade: _____ Track: _____
Parent/Guardian: _____ Phones: _____
Address: _____ City: _____ Zip: _____
Special Education Teacher: _____ Phone: _____
OT: _____ SLP: _____
PT: _____ Vision Specialist: _____
Regular Education Teacher: _____

Reason for Referral: Please describe the problems your student is having participating in his educational program. _____

Special Education Eligibility

- | | |
|---|--|
| <input type="checkbox"/> Orthopedic Impairment | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Deaf/Blindness |
| <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Vision Impairment |
| <input type="checkbox"/> Multiple Disabilities | <input type="checkbox"/> Other Health Impairment |
| <input type="checkbox"/> Communication Disorder | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Specific Learning Disabilities | <input type="checkbox"/> Emotional Disturbance |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Behavior Disordered |
| <input type="checkbox"/> Developmental Delay (ages 3 through 7) | <input type="checkbox"/> 504 Accommodation |

Related Services

Type of Service	Hours Per Week	Name of Provider
_____	_____	_____
_____	_____	_____

Time in Regular Education Class (Hours per week)

Is this student served in a regular education class? Yes No
If yes, specify locations and time: _____
If yes, is teacher or paraprofessional support provided? Yes No

Medical Diagnosis

- Down Syndrome
- Unknown

Neurological Disease (specify): _____
 Other Syndrome: _____

Vision

Date of most recent formal test/screening: _____

Results: _____

Based on formal and informal measures, student exhibits:

- no visual impairment
- suspected visual impairment
- documented visual impairment

Hearings

Date of most recent formal testing/screening: _____

Results: _____

Based on formal and informal measures, student exhibits:

- no hearing loss
- suspected hearing loss
- mild hearing loss (left ear; right ear; both)
- Moderate hearing loss (left ear; right ear; both)
- Severe hearing loss (left ear; right ear; both)
- Deaf

Specific Information about your student will help us provide better assistive technology services. Please use this checklist to indicate area of concerns.

Student is experiencing difficulty accessing education in the following areas :

- Communication
- Handwriting (legibility)
- Written Expression
- Spelling
- Reading
- Math
- Other academic subjects. Describe: _____

Organization (describe): _____

Participating in inclusive setting (describe) : _____

Accessing Print Materials: _____

- Access to Educational Materials due to physical handicap.
- Toys
 - Computer
 - Books
 - Other (describe): _____

Principal's Signature: _____ **Date:** _____