



ASSISTIVE TECHNOLOGY CONSULTATION REQUEST

Name of Student: _____ Date: _____

Date of Birth: _____ School: _____

Eligibility: _____ Grade: _____

Teacher: _____

Team Members:

Referral Source: _____

Contact Information: _____

Parent Contact: _____

What is the primary reason for this referral?

List the accommodations/materials/equipment currently being used by the student to access the curriculum:

What do you want the student to be able to do, in relationship to the IEP goals, if/when using assistive technology?

Please send completed form to Building Administrator and SRESA Regional Supervisor.