PLATTSBURGH CITY SCHOOL DISTRICT
Special Education Office
49 Broad Street
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# Assistive Technology Referral/Identification Guide

Student's Name: _____ DOB: _____ Age: ____

School District: _____ Grade: _____

School Contact Person _____ Phone _____ Email _____

Person(s) Completing Guide _____

Date: _____

Parent/Guardian Name(s) _____ Phone _____

Address: _____

Student's Primary Language _____

**Disability** (Check all that apply)

| | | |
|---|---|---|
| ____Speech/Language | ____Significant Developmental Delay | ____Specific Learning Disability |
| ____Cognitive Disability | ____Other Health Impairment | ____Hearing Impairment |
| ____Traumatic Brain Injury | ____Autism | ____Vision Impairment |
| ____Emotional/Behavioral Disability | ____Orthopedic Impairment-Type_____ | |

**Current Age Group** (check one)

| | | |
|---|---|---|
| ____Elementary | ____Middle School | ____Secondary |

**Classroom Setting** (check one)

| | | |
|---|---|---|
| ____Regular Education Classroom | ____Resource Room | ____Self-Contained |
| ____Home | ____Other _____ | |

**Current Service Providers** (check one)

____Occupational Therapy ____Physical Therapy ____Speech/Language
____Other(s) _____

**Medical Considerations** (check all that apply)

____History of seizures
____Degenerative medical condition
____Has multiple health problems
____Has frequent ear infections
____Allergies to:
_____

____Fatigues easily
____Has frequent pain
____Has frequent upper respiratory infections
____Has digestive problems

____Currently taking medication(s) for:
_____

____Other-Describe briefly
_____

**Assistive Technology Currently Used** (check all that apply)

____None
____Manual communication board
____Low tech vision aids
____Environmental control unit/EADL
____Manual or Power Wheelchair
____Voice Recognition
____Adaptive Input – Describe:
_____

____Low tech writing aids
____Augmentative communication system
____Amplification System
____Computer (MAC or PC)
____Word Prediction
____Text to Speech/Speech to text

____Other:
_____
_____

**Assistive Technology Tried**

Please describe any other assistive technology previously tried, length of trial, and outcome (how did it work or why it didn't work):

_____

_____

_____

_____

_____

**Referral Question**

What task(s) does the student need to do that is currently difficult or impossible, and for which assistive technology may be an option? _____

_____

**Assistive Technology Evaluation Team**

Based on the referral question, select the sections of the Student Information Guide to be completed.

____Section 1 Seating, Positioning and Mobility
____Section 2 Communication
____Section 3 Computer access
____Section 4 Motor aspects of writing
____Section 5 Composition of Written material
____Section 6 Reading
____Section 7 Mathematics
____Section 8 Organization
____Section 9 Recreation and Leisure
____Section 10 Vision
____Section 11 Hearing
____Section 12 General