JOHNSTON PUBLIC SCHOOLS

Special Services

REFERRAL FOR ASSITIVE TECHNOLOGY EVALUATION

Date: _____

Name of Child: _____ DOB: _____

School: _____ Grade: _____

Teacher: _____

Annual IEP Review Date: _____ Reeval Date: _____

TEAM PARTICIPANTS:

Parent_____ Special Educator_____

Chair_____ Regular Educator_____

Other_____ Other_____

Other_____ Other_____

Referral for Assistive Technology Services: (ATS)
_____Functional evaluation/Consultation
_____Coordination of other services with ATS
_____Training/technical assistance for student/family
_____Training/technical assistance for staff/assistants
_____Other (specify)_____

1.Describe the student's needs: _____
_____

2. What accommodations and modifications are currently being provided for the student? _____
_____

3. How do you expect Assistive Technology to support the student in the educational setting? _____
_____

4. Please identify those issues that you would like addressed as part of this referral: _____
_____

Comments/Additional Information_____
_____

Please attach any additional information to assist in determining AT needs.