

**Referral for Assistive Technology Services**

***This form must be accompanied by an Authorization from the district Special Education Administrator and copies of current records.***

# Student Name: Date: District: D.O.B.:

**School: Grade:**

**IEP Team Contact Information:**

|  |  |  |
| --- | --- | --- |
| **Name/Role** | **E-Mail Address** | **Phone Number** |
| Primary Contact: |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

What task(s) does the student currently have difficulty with?

What accommodations/modifications/assistive technology tools are currently being used?

How do you expect Assistive Technology to support the student’s needs?

Identify specific needs you would like addressed as part of this referral.

Identify any equipment/software you would like considered as part of this referral.

Signature/Title

*Please return completed form to Jennifer Martinous, OTR/L, ATP, Executive Director, TechACCESS of RI* [*jenm@techaccess-ri.org*](mailto:jenm@techaccess-ri.org) *or fax to: (401) 463-3433*