Referral/Question Identification Guide

Student's Name_____ Date of Birth_____ Age_____

School District of Residence_____ School_____ Grade_____

School Contact Person_____ Phone_____

Persons Completing Guide_____

_____ Date_____

Parent(s) Name_____ Phone_____

Address_____

Student's Primary Language_____ Family's Primary Language_____

Disability (Check all that apply.)

- ❒ Speech/Language
- ❒ Cognitive Disability
- ❒ Traumatic Brain Injury
- ❒ Emotional/Behavioral Disability
- ❒ Orthopedic Impairment – Type_____
- ❒ Significant Developmental Delay
- ❒ Other Health Impairment
- ❒ Autism
- ❒ Specific Learning Disability
- ❒ Hearing Impairment
- ❒ Vision Impairment

Current Age Group

- ❒ Birth to Three
- ❒ Early Childhood
- ❒ Elementary
- ❒ Middle School
- ❒ Secondary

Classroom Setting

- ❒ Regular Education Classroom
- ❒ Resource Room
- ❒ Self-contained
- ❒ Home
- ❒ Other_____

Current Service Providers

- ❒ Occupational Therapy
- ❒ Physical Therapy
- ❒ Speech Language
- ❒ Other(s)_____

Medical Considerations (Check all that apply.)

- ❒ History of seizures
- ❒ Has degenerative medical condition
- ❒ Has multiple health problems
- ❒ Has frequent ear infections
- ❒ Has allergies to_____
- ❒ Currently taking medication for_____
- ❒ Other – Describe briefly_____
- ❒ Fatigues easily
- ❒ Has frequent pain
- ❒ Has frequent upper respiratory infections
- ❒ Has digestive problems

_____

Other Issues of Concern_____

_____

_____

Assistive Technology Currently Used (Check all that apply.)

- ❒ None
- ❒ Manual Communication Board
- ❒ Low Tech Vision Aids
- ❒ Environmental Control Unit/EADL
- ❒ Power Wheelchair
- ❒ Voice Recognition
- ❒ Low Tech Writing Aids
- ❒ Augmentative Communication System
- ❒ Amplification System
- ❒ Manual Wheelchair
- ❒ Computer – Type (platform)_____
- ❒ Word Prediction
- ❒ Adaptive Input - Describe_____
- ❒ Adaptive Output - Describe_____
- ❒ Other_____

Assistive Technology Tried

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

_____ _____
Assistive Technology Number and Dates of Trial(s)

_____
Outcome

_____ _____
Assistive Technology Number and Dates of Trial(s)

_____
Outcome

_____ _____
Assistive Technology Number and Dates of Trial(s)

_____
Outcome

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?

_____

_____

_____

Parent Signature_____ Date _____

District Representative_____ Date _____

Return Original To:

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