

ASSISTIVE TECHNOLOGY REFERRAL FORM

Department of Special Education

Lincoln Public Schools

School Year: _____

Student's Name: _____ ID #: _____ Date: _____

Current School: _____ Current Grade: _____

Future School: _____ Verification: _____

Current Contact Person: _____ Email: _____ School Phone: _____

Future Contact Person: _____ Email: _____ School Phone: _____

Our concern is in the area of (check those that apply):

Communication

Literacy

Motor

Computer Use

Vision

(Attach Checklist)

Have you made other referrals on this student? Please list:

Please describe what you want this student to be able to do:

What is preventing this student from performing this task?:

How will assistive technology help this student perform the task:

Any other information that is significant:

PLEASE ADD MORE INFORMATION ON THE BACK IF NEEDED. Administrator signature required before submitting form.

Required signatures and email address' of staff involved.

Administrator: _____ Email: _____

IEP Case manager: _____ Email: _____

Resource Teacher: _____ Email: _____

Classroom Teacher: _____ Email: _____

SLP: _____ Email: _____

OT: _____ Email: _____

PT: _____ Email: _____

Vision: _____ Email: _____

Other: _____ Email: _____