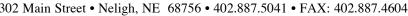
Referral Date:	
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Educational Service Unit #8 Special Education Assistive Technology Team 302 Main Street • Neligh, NE 68756 • 402.887.5041 • FAX: 402.887.4604





Assistive Technology Referral Form

Student:	DOB:	Grade:
MDT Verification:	School:	
Case Manager (CM):	CM Emai	l:
Identify the student's limitation(s) that impede fur	nctioning and learning:	
What type of assistance from the AT team does the Consultation Student E		
Identify areas where the student is having difficult	ty:	
Sensory Impairment	Written Language	
☐ Math	Communication	
Reading	Fine Motor/Handwriting	
☐ Mobility (Gross Motor/Transitioning)	Learning/Study Skills	
☐ Computer Access ☐ Positioning/Seating	☐ Other (physical education, re	ecreational/leisure, etc.)
What assistive technologies, accommodations, mostudent's needs?	odifications, or strategies have been or are	presently being implemented to address the
Identify the IEP Goal/Objectives(s) the IEP team I	believes AT may help achieve (attach addi	tional pages if needed).
Please return the following forms to the Assistive process.	Technology Team at the address above. I	Failure to do so will delay the referral

- □ Completed referral
- □ Copy of current IEP
- □ Signed Release of Information form from the parent