Referral Date: _____

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 Email: _____

Identify the student's limitation(s) that impede functioning and learning:

_____

_____

_____

What type of assistance from the AT team does the IEP team request?

☐ Consultation ☐ Student Evaluation ☐ In-Service

Identify areas where the student is having difficulty:

☐ Sensory Impairment
☐ Math
☐ Reading
☐ Mobility (Gross Motor/Transitioning)
☐ Computer Access
☐ Positioning/Seating
☐ Written Language
☐ Communication
☐ Fine Motor/Handwriting
☐ Learning/Study Skills
☐ Other (physical education, recreational/leisure, etc.)

What assistive technologies, accommodations, modifications, or strategies have been or are presently being implemented to address the student's needs?

_____

_____

_____

Identify the IEP Goal/Objectives(s) the IEP team believes AT may help achieve (attach additional pages if needed).

_____

_____

_____

Please return the following forms to the Assistive Technology Team at the address above. Failure to do so will delay the referral process.

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