

CONSIDERATION OF NEED FOR ASSISTIVE TECHNOLOGY SERVICES

Be sure to review "Using SETT in Addressing Assistive Technology on the IEP" in the IEP before requesting this service.

(Click on light bulb icon under the Assistive Technology tab of IIEP.)

Date Sent: _____ Date Received: _____ (by Assistive Tech Evaluator)

GENERAL INFORMATION:

Student Name: _____ STN: _____ DOB: _____ Age: _____

Parent Name: _____

Phone: _____

School: _____ Teacher of Record: _____ Grade: _____ School Year: _____

School Contact/Email: _____ School phone: _____

Hours/Days of Attendance: _____

Student's Area(s) of Eligibility: _____ (If MD, list all)

Student's OT: _____ PT: : _____ SLP: _____ (if applicable)

STUDENT'S LEVELS: (Please use back of this page to continue if not enough space is available below.)

Math: _____ Reading: _____ Written Language: _____

Listening Comprehension (if available and pertinent): _____

Student's Speech and Language Information: _____

Adaptive Behavior Scores/information: _____

Hearing and/or Vision information (if applicable): _____

STUDENTS ASSISSTIVE TECHNOLOGY CONCERNS: (Please use back of this page to continue if not enough space is available below.)

What current IEP goals/benchmarks do you feel should be augmented by Assistive Technology?

What other student issues or concerns do you feel might be addressed with Assistive Technology?

What other (if any) Assistive Technology solutions are in place currently? Describe their effectiveness.

Submit this form along with Referral for Observation/Consultation to the Assistive Technology Coordinator.