CONSIDERATION OF NEED FOR ASSISTIVE TECHNOLOGY SERVICES

Be sure to review "Using SETT in Addressing Assistive Technology on the IEP" in the IIEP 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 TECHOLOGY 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.