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educational excellence through leadership, partnership, and innovation

Assistive Technology Support Request

Capital Area Intermediate Unit
Attn: Central Referral
55 Miller Street
Enola, PA 17025-1640
Phone: 732-8400

Student's Name: _____ School District or Agency: _____

Contact person: _____ Phone: _____ E-mail: _____

Date: _____ Date of parental notification: _____

Student's medical diagnosis: _____

Services student receives: Occupational Therapy ☐ Physical Therapy ☐

Vision ☐ Hearing ☐ Speech & Language ☐

The individual named above is being considered for an assistive technology (AT) team assessment and AT support services. The CAIU Assistive Technology staff works with the local school district or agency and the family in identifying the individual's assistive technology needs, demands of the individual's environments and curricula, and appropriate assistive technology equipment and services. Assessing these parameters is an ongoing process and takes place in functional environments. All team members are encouraged and expected to contribute to this assessment. No formal report is written; however, assessment observations are documented and shared.

List the members of the assessment team. The team must include a **parent or guardian** and **two persons who work directly with the student** at school or the agency. If the team is considering assistive technology communication options, a speech language pathologist must be involved in the team meeting. If the team is considering assistive technology writing options, an occupational therapist must be involved in the team meeting. If the student has vision concerns, a vision itinerant/therapist must be involved in the team meeting.

Name:	**Position:**

*Complete both sides of this form and return it and the **CAIU Referral Request Form** to Central Referral at the address above.*

Revised 6/29/09

Assistive Technology Questionnaire

Student's name: _____ Teacher's name: _____

Type of classroom placement and grade level (e.g., 4th grade regular education with learning support services):

_____

Adaptive equipment used (e.g., wheelchair, writing device, vocal output device):

_____

Passed school vision screening ☐ Date of vision screening: _____

Passed school hearing screening ☐ Date of hearing screening: _____

Comments on vision and hearing (if visually impaired, designate blind or low vision and the student's visual acuity): _____

Communication Status (check those that apply)

- ☐ Recognizes objects/pictures
- ☐ Uses facial expressions
- ☐ Uses gestures
- ☐ Makes sounds
- ☐ Makes wants known
- ☐ Indicates yes/no
- ☐ Responds to communication interaction
- ☐ Understands speech of others
- ☐ Follows instructions
- ☐ Speaks in words at times
- ☐ Initiates communication interaction
- ☐ Asks questions
- ☐ Uses sign language
- ☐ Uses a communication board

Current level of receptive language (age or developmental level of functioning):

_____

Current level of expressive language:

_____

Comments:

Writing and Typing Status (check those that apply):

- ☐ Does not print/write
- ☐ Printing/writing is illegible
- ☐ Prints/writes legibly, but takes a long time
- ☐ Does not type
- ☐ Types slowly with one finger
- ☐ Types slowly with more than one finger
- ☐ Types slowly using headstick/pencil
- ☐ Fatigues easily when writing/typing
- ☐ Has used a computer with help
- ☐ Has used a computer independently
- ☐ Has used computer adaptations (e.g., alternate keyboard, switch)

Comments:

Motor Abilities (check those that apply):

- ☐ Walks independently
- ☐ Walks with assistance
- ☐ Uses wheelchair
- ☐ Has at least one consistent, intentional, isolated movement (e.g., one finger to type, head movement to access mounted switch)

Describe student's motor skills and range of motion: