Referral/Question Identification Guide

Student’s Name_________________________________________ Date of Birth__________________________ Age________________
School_________________________________________________ Grade__________
School Contact Person____________________________________ Phone______________
Persons Completing Guide________________________________________
Date____________________
Parent(s) Name_________________________________________ Phone______________
Address____________________________________________________
Student’s Primary Language___________________ Family’s Primary Language____________

Disability  (Check all that apply.)
☐ Speech/Language  ☐ Significant Developmental Delay  ☐ Specific Learning Disability
☐ Cognitive Disability  ☐ Other Health Impairment  ☐ Hearing Impairment
☐ Traumatic Brain Injury  ☐ Autism  ☐ Vision Impairment
☐ Emotional/Behavioral Disability
☐ Orthopedic Impairment – Type________________

Current Age Group
☐ Birth to Three  ☐ Early Childhood  ☐ Elementary
☐ Middle School  ☐ Secondary

Classroom Setting
☐ Regular Education Classroom  ☐ Resource Room  ☐ Self-contained
☐ Home  ☐ Other________________

Current Service Providers
☐ Occupational Therapy  ☐ Physical Therapy  ☐ Speech Language
☐ Other(s)________________

Medical Considerations  (Check all that apply.)
☐ History of seizures  ☐ Fatigues easily
☐ Has degenerative medical condition  ☐ Has frequent pain
☐ Has multiple health problems  ☐ Has frequent upper respiratory infections
☐ Has frequent ear infections  ☐ Has digestive problems
☐ Has allergies to________________
☐ Currently taking medication for________________
☐ Other – Describe briefly________________

Other Issues of Concern________________
### Chapter 1 - Assistive Technology Assessment

#### Assistive Technology Currently Used  
(Check all that apply.)

- [ ] None
- [ ] Manual Communication Board
- [ ] Low Tech Vision Aids
- [ ] Environmental Control Unit/EADL
- [ ] Manual or Power Wheelchair
- [ ] Voice Recognition
- [ ] Adaptive Input - Describe
- [ ] Adaptive Output - Describe
- [ ] Other

#### Assistive Technology Tried

Please describe any other assistive technology previously tried, length of trial, and outcome (how did it work or why didn’t it work.)

<table>
<thead>
<tr>
<th>Assistive Technology</th>
<th>Number and Dates of Trial(s)</th>
<th>Outcome</th>
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#### REFERRAL QUESTION

What task(s) does the student need to do that is currently difficult or impossible, and for which assistive technology may be an option?

Based on the referral question, select the sections of the Student Information Guide to be completed.  
(Check all that apply.)

- [ ] Section 1  Seating, Positioning and Mobility
- [ ] Section 2  Communication
- [ ] Section 3  Computer Access
- [ ] Section 4  Motor Aspects of Writing
- [ ] Section 5  Composition of Written Material
- [ ] Section 6  Reading
- [ ] Section 7  Mathematics
- [ ] Section 8  Organization
- [ ] Section 9  Recreation and Leisure
- [ ] Section 10  Vision
- [ ] Section 11  Hearing
- [ ] Section 12  General