ASSISTIVE TECHNOLOGY REFERRAL FORM
DISTRICT APPROVAL

School District Administrator/(Legal Guardian's School District) Signature
Date

On-site Contact Person/Equipment Manager (note responsibilities on instruction page)
SIGNATURE Title Name (PRINT) Email (PRINT)

Team Members (SIGNATURE) Title Name (PRINT) Email (PRINT)
家长/家长
校长/LEA
特殊教育教师
特殊教育教师

PARENT INFORMATION
Name: ___________________________ Address: ___________________________
Phone: (H): _____________________ (W): ___________________________
(City, State, Zip)

STUDENT INFORMATION
Name: ___________________________ DOB: __________, Grade________________
Facility: ___________________________ Home School District: ____________________

Assistive Technology Consultation is requested because: (list specific needs for curricular access)


DOES THE STUDENT RECEIVE SUPPORT AND/OR SERVICES WITH:
☐ IEP ☐ Hearing Impairment ☐ Communication
☐ PA Chapter 15/504 ☐ Vision Impairment ☐ Fine/Gross Motor

FOR ATP STAFF ONLY

Date referral received: __________________ Date ATP processed: __________________
Assistive Technology Consultant Assigned: __________________ Date Received: __________

Ar, Equal Rights And Opportunities Employer