NEENAH JOINT SCHOOL DISTRICT AT-Ref.1
SPECIAL EDUCATION
ASSISTIVE TECHNOLOGY REFERRAL

Date:_____

Student Name:	DOB:	Grade:	School:
Parent/Guardian Name:	Address:		Phone:
Referral Source:	IEP Chairperson:		

REASON FOR REFERRAL

_____ Communication
_____ Environmental Modifications
_____ Listening/Hearing
_____ Mobility & Positioning
_____ Recreation/Play
_____ Vision
_____ Fine Motor/ Written Communication
_____ Other_____

EXPECTATIONS

Has any assistive technology been tried in the past? _____ Yes _____ No
If so, please describe: _____
_____
_____

Is any assistive technology currently being used? _____ Yes _____ No
If so, please describe: _____
_____
_____

SPECIAL EDUCATION INFORMATION

Is child currently receiving special education services? _____ Yes _____ No

If yes, please check all that apply:

_____ Cognitive Disability
_____ Emotional Disturbance
_____ Learning Disability
_____ Orthopedic Impairment
_____ Other Health Impairment
_____ Special Physical Education
_____ Speech/Language Disability
_____ Hearing Impairment
_____ Vision Impairment
_____ Autism
_____ Traumatic Brain Injury
_____ Occupational Therapy
_____ Physical Therapy

Present Program/Placement:_____Teacher:_____

Discussed at PPC meeting on _____ _____
Signature of Building Administrator

11/00 **Return to Special Education Office**