

Utah  
Augmentative  
Alternative  
Assistive  
Communication &  
Technology Teams

# Assistive Technology Referral Form

Special Education Services  
 U.A.A.A.C.T.  
 Team U

Student Name: \_\_\_\_\_ District: \_\_\_\_\_  
 Placement: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Teacher: \_\_\_\_\_ School: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State: \_\_\_\_\_  
 Person Making Referral: \_\_\_\_\_ Position: \_\_\_\_\_  
 Date parent/guardian signed permission to assess: \_\_\_\_\_ Reading Level: \_\_\_\_\_

*The following information will help the Assistive Technology Team to assist the school team in determining appropriate adaptations that may allow the student better access to his/her educational program and curriculum.*

List the IEP goals/objectives that the student is unable to meet that *might* be accomplished with additional assistive technology equipment or services: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What is the primary reason for referring this student for an Augmentative Team evaluation? \_\_\_\_\_  
 \_\_\_\_\_

What is the student's primary barrier to more successful participation in his/her educational program or curriculum?  
 Verbal Communication *(If so, you will need to fill-out a Verbal Communication Pre-assessment Form)*  
 Written Communication *(If so, you will need to fill-out a Written Communication Pre-assessment Form)*

Example(s): \_\_\_\_\_  
 \_\_\_\_\_

**Team Members involved in referral decision (there must be at least 3):**

<u>Signature</u>	<u>Title/Position</u>	<u>Signature</u>	<u>Title/Position</u>
_____	Teacher	_____	Other: _____
_____	LEA	_____	Other: _____