LUZERNE INTERMEDIATE UNIT
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ASSISTIVE TECHNOLOGY REQUEST FORM

****PLEASE DOWNLOAD AND SAVE THIS DOCUMENT TO YOUR DESKTOP PRIOR TO TYPING ON IT. YOU THEN MUST SAVE IT AGAIN PRIOR TO SENDING TO EMAIL ADDRESS (assistivetech@liu18.org).**
****AT REQUESTS WILL BE PROCESSED FROM THE BEGINNING OF THE SCHOOL YEAR TO MAY 15TH. IF REQUESTS ARE SUBMITTED AFTER MAY 15TH, MEETINGS WILL BE SCHEDULED FOR THE FOLLOWING SCHOOL YEAR.**

SECTION 1:

Student: _____ Age:_____ Grade:_____

School: _____ Phone:_____

Educational Placement/Program_____

Referral Person: _____Email_____ Phone:_____

Program Supervisor: _____ Email_____ Phone:_____

Occupational Therapist: _____ Email_____

Physical Therapist: _____ Email_____

Speech Therapist: _____Email_____

Other: _____ Email_____

SECTION 2:

Are you requesting Option B: Consultation ◯ yes ◯ no

Are you requesting Option C: SETT Facilitation ◯ yes ◯ no

Reason for referral: Describe the difficulties your student is having while participating in his/her educational program. In what area(s) is the student not making effective progress or not accessing the general education curriculum.

Specific information about your student will help us provide better assistive technology services. Please indicate the areas of concern using the checklist and space provided.

☐ Communication	
☐ Handwriting	
☐ Written Expression	
☐ Spelling	
☐ Reading	
☐ Math	
☐ Organization	
☐ Accessing Print Materials	

SECTION 3

Pertinent Background Information: (Describe student's disability, educational background, current level of educational performance, other useful information)

SECTION 4

Current assistive technology being used or previously tried: (Describe strategies/devices already tried, lengths of trials, and outcomes)

Signature of person making the referral: _____ Date:_____

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