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| **DESERT/MOUNTAIN SPECIAL EDUCATION LOCAL PLAN AREA**  **DESERT/MOUNTAIN CHARTER SPECIAL EDUCATION LOCAL PLAN AREA**  17800 HIGHWAY 18 • APPLE VALLEY, CA 92307  (760) 552-6700 • (760) 242-5363 FAX  **Assistive Technology Assessment Referral** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **STUDENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Student Name: | | | | | |  | | | | | | | | | | | | | | | | | Date of Birth: | | | | | |  | | | | | | | | | | | | | | |
| Medi-Cal No: | | | | |  | | | | | | | | | | | | | Grade: | | | | | |  | | | | | | | | | Gender: | | | | | | Male | | | Female | |
| Disability: | | |  | | | | | | | | | | | | | | | | | | | Medical Diagnosis: | | | | | | |  | | | | | | | | | | | | | | |
| School Site: | | | |  | | | | | | | | | | | | | | | | | | | | Teacher Name: | | | | |  | | | | | | | | | | | | | | |
| District of Attendance: | | | | | | | | | |  | | | | | | | | | | District of Residence: | | | | | | | | |  | | | | | | | | | | | | | | |
| Parent/Guardian: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Home Phone: | | | | |  | | | | | | | Work Phone: | | | |  | | | | | | | | | | | | Other Phone: | | | | | | | |  | | | | | | | |
| Street Address: | | | | | | |  | | | | | | City: | | |  | | | | | | | | | | | State: | | | |  | | | | | | | Zip Code: | | |  | | |
| Mailing Address: | | | | | | | |  | | | | | City: | | |  | | | | | | | | | | | State: | | | |  | | | | | | | Zip Code: | | |  | | |
|  | | | | | | | | |  | | | |  | | |  | | | | | | | | | | |  | | | | |  | | | | |  | | | |  | | |
| Current special education services/placement: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Time/day student can be observed performing skill/activity of concern: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Contact Person: | | | | | | |  | | | | | | | | | | Contact Phone: | | | | | | | | |  | | | | | | | | | Fax: | | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **additional information required** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Describe the following area(s) of concern:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  | | --- | | 1. *Switch Access:* | |  | | 1. *Computer Access:* | |  | | 1. *Augmentative Communication:* | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **2. What question(s) is an Assistive Technology Assessment intended to answer?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **3. Please mark the adaptive equipment currently being used:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | Wheelchair | Leg Braces | Stander | | Communication Device | | Crutches | Computer | Hand Splints | | Body Jacket | | Specialized Classroom Chair | Switches | Other: |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Additional comments:** *(For example: emotional/behavior concerns; medical issues; hearing or vision impairments, etc.)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referred By: | | | | |  | | | | | | | | | | | | | | | | Title: | | | |  | | | | | | | | | | | | | | | | | | |
| Contact Phone: | | | | | | |  | | | | | | | Email Address: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Special Education Director Signature: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | Date: | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Attach a copy of the student’s latest psychological report and current IEP and include any additional information such as doctor reports, speech/language reports, previous OT and/or PT reports, etc.**  **PLEASE NOTE: Incomplete referrals will be returned for completion and resubmission.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |