Revised 9/29/2014

Date Received: _____

District School Board of Pasco County

Assistive Technology/CORE Team Student Referral Form

Demographics

Student: _____ Student #: _____ DOB: _____ Date: _____
School: _____ Grade: _____ Case Manager: _____

Teachers/therapists serving the student: _____

The school-based team has completed the Assistive Technology Consideration Checklist/Screening Tool
☐ **Yes** ☐ **No** (If yes, please attach. If no, complete The Assistive Technology Consideration Checklist/Screening Tool with the T/IEP Team and determine if a referral is warranted).

ESE Program(s): (Circle all that apply)

ASD	DD	D/HH	EBD	HHB
InD	LI	OHI	OI	OT
PT	SI	SLD	TBI	VI

Educational Placement: _____

Is the student currently being considered for an additional program and/or related service? ☐ Yes ☐ No

If yes, list: _____

Medical Diagnosis (List all): _____

Allergies (Particularly food): _____

Medication(s): _____

Parent/Legal Guardian: _____ Home Phone: _____ Work Phone: _____

Home Address: _____

What language is spoken at home? ☐ English ☐ Spanish ☐ Other: _____

Student uses:

☐ amplification system(s)	☐ communication system	☐ crutches/walker
☐ orthotics/prosthetics	☐ switches	☐ vision aid(s)
☐ visual materials	☐ wheelchair	☐ writing adaptations

other: _____

YES	NO	
☐	☐	Does student have any problems with vision?
☐	☐	Does student have any problems with hearing?
☐	☐	Can the student point with one finger?

Has the student previously received support by the AT/CORE Team: ☐ Yes, date _____ ☐ No

If yes, what recommendations from the previous report has the team **not** been able to implement and why? _____

_____

_____

_____

Why are you referring this student? What is the student unable to do that limits his/her success in the school environment?

Please state the student's T/IEP goal(s) which are impacted.

List accommodations or interventions **tried thus far**. Please include input from **all individuals** working with the student (OT, PT, SLP, teachers, family, etc.) Continue on back page if needed.

Accommodation or intervention	Attempted by	Length of trial	Results

Please list additional information that may be useful in assisting the team. (e.g. placement changes, family changes/history, recent medical diagnosis, etc.)

Can the student independently manipulate items within the classroom environment? (Computer, tape player, books, etc.) ☐ Yes ☐ No

Can the student access a standard keyboard for word processing? ☐ Yes ☐ No

What motivates the student? (food, praise, toys, music, etc.) _____

Team Signatures: (All program teachers and related service providers should sign this form, or documented contact from these staff members must be attached)

Administrator (required): _____ Date: _____

AT/Core Liaison: _____ Date: _____

Team Member: _____ Date: _____

Team Member: _____ Date: _____

Team Member: _____ Date: _____

Team Member: _____ Date: _____

Team Member: _____ Date: _____

Team Member: _____ Date: _____

Assistive Technology/CORE Team
Parent/Legal Guardian Notification of Support Services

I have been informed that my child will receive support from the District School Board of Pasco County's Assistive Technology/CORE Team. Services may include any or all of the following: consultation, observation, training, providing resources to T/IEP team members, and/or multi-disciplinary team assessment. My child's school has discussed these services with me. A report will be written by the Assistive Technology /CORE Team to provide recommendations. When completed, a copy of the report will be sent home.

If you have any additional questions, please contact Jeannine Welch in the Office of Student Support Programs and Services at the District Office (813) 794-2600.

Parent/Legal Guardian Information

Name (Parent/Legal Guardian)	Telephone Number
Parent/Legal Guardian Signature	Date

Please send the following to the AT/CORE Team:

- ☐ **Completed Assistive Technology/ CORE Team Student Referral Form**
  Obtain all signatures on referral form, including parent and AT/CORE Liaison
- ☐ **Student's T/IEP & supporting documentation**
- ☐ **Completed Assistive Technology Screening Form for Educational Planning**
- ☐ **Functional Behavior Assessment/Behavior Intervention Plan, if applicable**
- ☐ **Parent questionnaire(s) related to the area(s) of concern listed on this referral**

Once the referral packet has been completed please submit the required paperwork to your school-based Assistive Technology/CORE Team Liaison who will forward it to Kim Taylor at CSRMS. Once the referral has been received a member of the Assistive Technology/CORE Team will contact you.