WISD Assistive Technology Decision-Making Process

Form 1: Beginning the Process

Student's Name _____ Date of Referral: _____
Birthdate: _____ Age: _____ Grade/Placement: _____
School: _____ District: _____
IEP Eligibility: _____ Referring person:_____

Team Members: Please identify all team members involved with this student.
Check names of those who will serve on the AT team.

	Phone:
☐ Parent/Caregiver: _____	_____
☐ Teacher: _____	_____
☐ T/C: _____	_____
☐ Parapro: _____	_____
☐ OT: _____	_____
☐ PT: _____	_____
☐ Speech: _____	_____
☐ AT Consultant: _____	_____
☐ Psychologist: _____	_____
☐ Social Worker: _____	_____
☐ Administrator: _____	_____
☐ Other: _____	_____

Pertinent Medical/Physical Considerations:

☐ Health Problems ☐ Fine motor ☐ Hearing ☐ Behavior
☐ Seizures ☐ Hand/arm use ☐ Vision
☐ Fatigue/Attention ☐ Other: _____

Referral Question: What task(s) does the student need to do that is currently difficult or impossible, and for which assistive technology may be an option? _____

_____

_____

Based on the referral question, select areas of concern and check all areas that apply.

☐ Motor Aspects of Writing
☐ Fine Motor Related to Keyboarding, Computer or Device Access
☐ Composing Written Material
☐ Communication
☐ Reading
☐ Learning and Studying
☐ Math
☐ Recreation and Leisure
☐ Seating and Positioning
☐ Mobility
☐ Vision
☐ Hearing
☐ Environmental
☐ Other

Refer to the AT Guide for optional assessment tools for these areas if more information is needed.

Send copies of this form to: ☐ Building Principal/Supervisor ☐ Identified AT Team Members
☐ Special Ed Director ☐ Special Ed file/ca 60 ☐ Other _____
Date Sent: By:

Adapted from WATI Assessment Package (2004)