

**Initial Inquiry for Assistive Technology Evaluation**

*To be completed by School District Representative*

*If you have already completed Part I using the online AT Evaluation Request Form, please check here and complete only Part II.*

*I have submitted Part I using the online AT Evaluation Request Form.*

**Part I**

**STUDENT'S NAME:** \_\_\_\_\_

Age: \_\_\_\_\_ Sex:  Male  Female

**SCHOOL REPRESENTATIVE**

Name: \_\_\_\_\_ Position: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**SCHOOL/AGENCY INFORMATION**

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

**STUDENT INFORMATION**

**SPED Classification:**

- |   |   |
|---|---|
| <input type="checkbox"/> Autistic                 | <input type="checkbox"/> Learning Disability    |
| <input type="checkbox"/> Blind/Visual Impairment  | <input type="checkbox"/> Multiple Disabilities  |
| <input type="checkbox"/> Cognitive Disability     | <input type="checkbox"/> Orthopedic Disability  |
| <input type="checkbox"/> Communication Impairment | <input type="checkbox"/> Other Health Impaired  |
| <input type="checkbox"/> Deaf /HOH                | <input type="checkbox"/> Preschool Disabled     |
| <input type="checkbox"/> Emotionally Disturbed    | <input type="checkbox"/> Traumatic Brain Injury |

**Disability Details:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Placement:**

- |  |   |
|--|---|
| <input type="checkbox"/> General education classroom | <input type="checkbox"/> In-class support         |
| <input type="checkbox"/> Resource center             | <input type="checkbox"/> Self-contained classroom |
| <input type="checkbox"/> Private school              |   |

**Current Related Services:**

	School	Private	Private therapist contact info
PT	<input type="checkbox"/>	<input type="checkbox"/>	_____
OT	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech/Lang	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Intake Form Part II on:** \_\_\_\_\_

(child's name)

Child's primary mode of communication:

- speech
- PECS or other low-tech communication board
- augcomm device type: \_\_\_\_\_
- other reliable means of communication

Child's typical attention level:

- attends appropriately
- has difficulty staying on task
- very short attention span

In general, what are your goals for this assistive tech evaluation?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How do you envision assistive technology will help this child? **Check a maximum of 3**

- |   |   |
|---|---|
| <input type="checkbox"/> mechanics of writing                       | <input type="checkbox"/> assist with organization of school work                      |
| <input type="checkbox"/> provide an efficient means of note-taking  | <input type="checkbox"/> enable him/her to take tests and demonstrate what s/he knows |
| <input type="checkbox"/> increase the speed of his/her typing       | <input type="checkbox"/> provide access to the Internet/email                         |
| <input type="checkbox"/> improve the quality of written composition | <input type="checkbox"/> provide activities for recreation, leisure, and/or games     |
| <input type="checkbox"/> practice academic skills--subject: _____   | <input type="checkbox"/> other: _____   |
| <input type="checkbox"/> provide access to computers                |   |
| <input type="checkbox"/> increase reading comprehension             |   |
| <input type="checkbox"/> assist with spelling                       |   |

Has the child had an assistive technology evaluation in the past?  Yes  No

If yes, date: \_\_\_\_\_ By whom: \_\_\_\_\_

Primary recommendations of previous evaluation:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please return via:

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