TechACCESS of Rhode Island
Referral for Assistive Technology Services

This form must be accompanied by an Authorization from the district Special Education Administrator and copies of current records.

Student Name: _____ **Date:** _____

District: _____ **D.O.B.:** _____

School: _____ **Grade:** _____

IEP Team Contact Information:

Name/Role	E-Mail Address	Phone Number
Primary Contact:		

What task(s) does the student currently have difficulty with?

_____

_____

What accommodations/modifications/assistive technology tools are currently being used?

_____

_____

How do you expect Assistive Technology to support the student's needs?

_____

_____

Identify specific needs you would like addressed as part of this referral.

_____

_____

Identify any equipment/software you would like considered as part of this referral.

_____

Signature/Title _____

Please return completed form to Kelly Charlebois, ATP, Clinical Manager, TechACCESS of RI
kellyc@techaccess-ri.org or fax to: (401) 463-3433