

**TechACCESS of Rhode Island Referral for Assistive Technology Services *This form must be accompanied by a Payment Authorization.***

# Client Name: Date: Address: DOB: Referring Agency/Program:

**Contact Information:**

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

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

 What will assistive technology tools be used for? (Check all that apply)

|  |  |  |
| --- | --- | --- |
| * leisure
 | * employment
 | * education
 |
| * communication
 | * daily living skills
 |  |

Settings assistive technology is needed in: (check all that apply)

|  |  |  |
| --- | --- | --- |
| * home
 | * community
 | * education
 |
| * day program
 | * employment
 |  |

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

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.

Completed by:

*Please return completed form to Jennifer Martinous, OTR/L, ATP, Clinical Manager, TechACCESS of RI* *jenm@techaccess-ri.org* *or fax to: (401) 463-3433*