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?

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

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

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

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

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Signature/Title____

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