IU 17 BLaST
BRADFORD LYCOMING SULLIVAN TIOGA

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Canton, PA 17724
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Assistive Technology Consultation Request Form

Student name:	**Date of birth:**
Home school district:	**Diagnosis:**
School attending:	**School building:**
School address:	**Educational placement:** **Grade:**
Classroom teacher:	**Arrival time:** **Departure time:**
LEA:	**LEA phone:** **LEA email:**
Current IEP date: **PLEASE SUBMIT CURRENT IEP.**	**Current ER/RR date:**

Identify any area that may be keeping the student from accomplishing IEP goals that reflect his/her abilities, or identify any area in which the student is already using AT:

- ☐ Communication
- ☐ Reading
- ☐ Independent living
- ☐ Composing written material
- ☐ Math
- ☐ Positioning/seating/mobility
- ☐ Computer Access
- ☐ Study/organizational skills
- ☐ Environmental control
- ☐ Vision
- ☐ Hearing

Please indicate concerns regarding all areas of need checked above and student's functioning in classroom:

What communication strategies have been used previously? Were they successful?

Does the student currently receive therapy and/or other services? If so, please indicate name, service, and contact.

Speech Therapy	name: _____	e-mail: _____
Occupational Therapy	name: _____	e-mail: _____
Teacher of Visually Impaired	name: _____	e-mail: _____
Physical Therapy	name: _____	e-mail: _____
Other	name: _____	e-mail : _____

Signature of person completing form: _____ Date: _____

Signature of District Special Education Coordinator: _____ Date: _____

LEA signature is required prior to scheduling of AT consultation.