Otsego Northern Catskills BOCES
Itinerant and Related Services

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1914 Cty Rte 35 Milford, NY 13807
607-286-7715 ext 2608/2701
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Assistive Technology Consult

Date: ____________________ DOB: ________________________________
Student: ________________________________ Parents: ______________________________
School District: _________________________ Address: ______________________________
School Attending: _______________________ ______________________________
Teacher: ________________________________ Phone: ______________________________
Grade: ____________________
Program Placement: ____________________ IEP Classification: _______________________
Referred by: ____________________________
Name & Contact Info to Set up Consult: ____
____

Please attach a current IEP.

As CSE Chairperson for the ______________________________ School District, I understand there is no Assistive Technology evaluation. This is a consult only.

____
Signature of CSE Chairperson

Does the student receive any of the following: Name of Service Provider:

☐ Occupational Therapy ____
☐ Physical Therapy ____
☐ Speech/Language Therapy ____
☐ Visually Impaired Services ____
☐ Hearing Impaired Services ____
☐ Resource/Consultant Services ____
☐ Other (Please list) ____
____

Assistive Technology Consult Cntd.

Basic Achievement Levels

Reading Level: ______________________________

Written Expression: ______________________________

Math Level: ______________________________

How long does the student stay on task? ______________________________

1. Communication

Is the child verbal? _______ Yes _______ No

Does the child use a device for communication? (Dynavox, Macaw, Cheap Talk, etc)

_______ Yes _______ No

Is this a request for a communication consult? _______ Yes _______ No

2. Reading and Written Language

Can the child read at his/her current grade level? _______ Yes _______ No

Does the child write at his/her current grade level? _______ Yes _______ No

Please list any concerns you have relating to the child's reading and writing:

____

____

____

____

3. Physical Abilities

Please mark each of the following activities relating to the child, using the following key:

I - completes independently

N - needs help to complete task

U - unable to complete task

_______ Walk _______ Feed Self _______ Toilet

_______ Write _______ Access lights/TV _______ Dress

4. Computer Access

Please indicate if child has access to the following at school (S) and/or at home (H):

_______ PC (Dell, HP, etc) _______ Mac _______ Ipad/Tablet

_______ Chromebook _______ Alternate Keyboard

5. Is child able to purposefully: _______ click _______ double click

_______ click and drag _______ save a document/file

_______ open program _______ open file

Assistive Technology Consult Cntd.

6. Please list topics, games, or other known motivational tools used with the child:

____
____
____

7. Please list software the child currently uses:

____
____
____

8. Does the child currently use any assistive technology devices: _______ Yes _______ No
Please list:

____
____
____

Is there any other information you feel may help during the consult?

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ASSISTIVE TECHNOLOGY CONSULT
PARENT CONSENT FORM

Student Name:____

Please place an **X** in the appropriate box.

☐ Yes,
I give you permission to do an Assistive Technology consult of my child and to speak to his/her teachers.

☐ No,
I do not give you permission to do an Assistive Technology consult of my child.

Please sign and date. Thank you.

Signature: ____

Date: ____________________