

Seattle Schools - Special Education Services Request for Assistive Technology Consultation

Date of Request:

Student Name:

Student ID#:

Student Birth Date:

Student Pronouns:

School:

Room:

Grade:

If pre-K, AM or PM:

Referral Source:

Gen Ed Teacher:

Special Ed Teacher:

SLP:

OT:

PT:

IAs:

Caregiver/s Name:

Caregiver/s Email:

Primary Language (listed in IEPO):

Home Language (listed in IEPO):

Please indicate if the student receives Multilingual (ML) Services:

Please indicate if there are concerns related to Audiology needs:

Please indicate if there are concerns related to Vision needs:

Please indicate if this is a 504 related case:

Reason for Assistive Technology Consult.

Please describe the issue/s only in the area/s of concern:

Reading:

Writing (please also attach a writing sample):

Math:

Communication:

Computer Access:

What is the desired outcome:

**Please email this form to your Assistive Technology Specialist contact
OR to assistivetech@seattleschools.org**