# Center for Adaptive Technology Referral Form

## *Personal Information*

Client name ____________________________________________

Address ____________________________________________

City ______________________________ State __________ Zip __________

Phone (h) ______________________ Phone (w) ______________________

Date of birth __________

If a student, current school ____________________________ Grade __________

What computers are available in the school? ❑ Desktops ❑ Laptops

❑ Macintosh ❑ OSX ❑ OS9

❑ PC ❑ Win 2000 ❑ Win ME ❑ Win 95 or 98

If client is a child, please provide parent/guardian information below:

Parent/guardian name ____________________________________________

Address, if different form above ______________________________________

Phone (h) ______________________ Phone (w) ______________________

What is the client's diagnostic disability? ______________________________

Briefly describe the functional disability ______________________________

____________________________________________________________

If this evaluation is part of the PPT process, please send a copy of the IEP that indicates goals to be addressed by adaptive technology. If it is not part of a PPT, please indicate the goals for having this client use technology.

____________________________________________________________

____________________________________________________________

## *Employment Information*

Employment status

- ❑ Full time
- ❑ Part time
- ❑ Retired
- ❑ Unemployed but able to work
- ❑ Unemployed, not able to work
- ❑ Not applicable (student)

Primary occupation ____________________________________________

Primary job skill ____________________________________________________

Type of work experience

- ❑ Competitive
- ❑ Supported
- ❑ Unpaid
- ❑ Other ______________________________________________

## *Related Services*

Please indicate if the client has received or is currently receiving the following evaluations or services. Please include copies of relevant reports.

| Service or evaluation | Evaluator/agency | Date |
|---|---|---|
| IEP | ______________________ | ________ |
| Assistive technology | ______________________ | ________ |
| Occupational therapy | ______________________ | ________ |
| Physical therapy | ______________________ | ________ |
| Speech/language | ______________________ | ________ |
| Hearing | ______________________ | ________ |
| Visual | ______________________ | ________ |
| Neurological | ______________________ | ________ |
| Psychological | ______________________ | ________ |
| Other ________ | ______________________ | ________ |

It is also helpful to include a video of the student in an educational environment.

# *Language Skills*

**Spoken Language**

What is the client's native language? ________________
Does the client understand spoken English? ❑ yes ❑ no

Please indicate the client's main mode of communication:
- ❑ Intelligible speech ❑ Writing, no speech ❑ Sounds ❑ Signs, gestures
- ❑ Communication board: ___ with pictures ___ with symbols ___ with words
- ❑ AAC: ___ dedicated device ___ software-based AAC name ____________
  Access to AAC: ___ direct ___ switch ___ scanning ___ mouse alternative
  AAC language type: ___ picture symbols ___ spelling messages
  ___ constructing sentences with picture symbols

Please indicate area(s) of concern:
- ❑ Word retrieval ❑ Formulation of ideas ❑ Other ________________

**Receptive Language**

Please indicate area(s) of concern:
- ❑ Overall receptive language ❑ Understanding and following directions
- ❑ Other (describe) ____________________________________________

**Reading**

What is the client's reading level (grade)? _______

Please indicate area(s) of concern:
- ❑ Letter recognition ❑ Letter reversal
- ❑ Picture/icon recognition ❑ Comprehension
- ❑ Decoding

Does the client use any of the following for reading?
- ❑ Books on tape ❑ Books on CD ❑ Electronic dictionary
- ❑ Electronic text with reading software
  Name of software: __________________________

**Written Expression**

Please indicate area(s) of concern and describe below:
- ❑ Spelling ❑ Grammar ❑ Sentence structure
- ❑ Organization of ideas ❑ Word retrieval ❑ Proofreading/revision

____________________________________________________________

____________________________________________________________

____________________________________________________________

Does the client use any of the following for writing?
- ❑ Word processing ❑ Electronic dictionary.thesaurus
- ❑ Outlines ❑ Webbing, mind maps, clustering

## Vision

Please indicate which category best describes the client's vision:

- ❑ Normal
- ❑ Visual impairment, correctable with lenses
  Corrected acuity: left eye _______ right eye ________
- ❑ Visual impairment, not correctable with lenses
  Acuity: left eye __________ right eye ________
- ❑ Legally blind ❑ Totally blind
- ❑ Fluctuating vision ❑ Cortical vision impairment (CVI)
- ❑ Visual/perceptual problems

If applicable, please specify diagnosed visual disorder (for example, macular degeneration, retinitis pigmentosa, retinopathy):

______________________________________________________________

Please indicate area(s) of difficulty:

- ❑ Seeing a standard computer screen
- ❑ Seeing the keys on a standard keyboard
- ❑ Seeing the blackboard/whiteboard in a classroom
- ❑ Seeing a television screen

Do any of the following conditions negatively affect the ability to see?

- ❑ Glare ❑ Low contrast
- ❑ Bright lights ❑ High contrast
- ❑ Fluorescent lights ❑ Eye fatigue

Does the client currently use any of the following?

- ❑ Eyeglasses ❑ CCTV
- ❑ Magnifying lens ❑ Large print
- ❑ Books on tape ❑ Braille
- ❑ Electronic text ❑ Other ____________________

## Hearing

Please indicate which category best describes the client's hearing:

- ❑ Normal
- ❑ Hearing impairment, assisted by hearing aid or implant
- ❑ Hearing impairment, not assisted by hearing aid or implant
- ❑ Deaf
- ❑ Central Auditory Processing Disorder (CAPD) – Diagnosis date: ___________

Please indicate area(s) of difficulty:

- ❑ Hearing the human voice
- ❑ Hearing beeps or other sounds made by a computer
- ❑ Hearing synthesized speech on a computer
- ❑ Seeing a television screen

Does the client use: ❑ ASL or Signed English ❑ Speech reading

## *Physical Coordination*

Please indicate area(s) of difficulty:

- ❑ Control of head, neck
- ❑ Control of facial muscles, swallowing
- ❑ Coordination or use of left hand/fingers
- ❑ Coordination or use of left arm
- ❑ Coordination or use of right hand/fingers
- ❑ Coordination or use of right arm
- ❑ Coordination or use of legs, feet
- ❑ Ability to be in a standard seating posture
- ❑ Endurance
- ❑ Mobility

Does the client currently use any of the following?

- ❑ Cane
- ❑ Walker
- ❑ Crutches
- ❑ Manual wheelchair
- ❑ Power wheelchair or scooter
- ❑ Other ____________________

## *Handwriting*

Please indicate hand dominance ______ left ______ right ______ ambidextrous

Please indicate area(s) of difficulty with handwriting:

- ❑ Formation of letters
- ❑ Printing
- ❑ Near point copying
- ❑ Spacing of work on paper
- ❑ Speed
- ❑ Reversals
- ❑ Cursive
- ❑ Far point copying
- ❑ Fatigue
- ❑ Productivity

Does the client currently use any of the following?

- ❑ Standard pen or pencil
- ❑ Slant board
- ❑ Other ____________________
- ❑ Adapted pen or pencil grip
- ❑ Adapted paper

## Organization

Please indicate area(s) of difficulty:

- ❑ Distractibility
- ❑ Completion of tasks
- ❑ Management of belongings
- ❑ Management of personal space

## Personal Preferences

How does the client learn best?

- ❑ Through visual information
- ❑ Through auditory information
- ❑ By reading
- ❑ Hands-on

Please list three areas of interest that may be motivators during the evaluation (for example, sports, pets, travel, music):

______________________________

______________________________

## Computer Experience

Does the client use a computer at school? ❑ Yes ❑ No

Specify platform: ❑ PC ❑ Macintosh

Who provides computer user support? ______________

Does the client use a computer at home? ❑ Yes ❑ No

Specify platform: ❑ PC ❑ Macintosh

Who provides computer user support? ______________

Does the client use a computer at work? ❑ Yes ❑ No

Specify platform: ❑ PC ❑ Macintosh

Who provides computer user support? ______________

Indicate which items the client uses:

- ❑ Standard keyboard
- ❑ Standard mouse
- ❑ Portable note taker (such as AlphaSmart) – specify: ______________
- ❑ Handheld computer (such as a Palm) – specify: ______________
- ❑ Adaptive hardware – specify: ______________
- ❑ Adaptive software – specify: ______________

# *Keyboarding Experience*

Please indicate the client's *current* input method:

❑ Keyboard with
- ❑ two hands, all fingers
- ❑ two hands, fewer than five fingers per hand
- ❑ two hands, isolating one finger per hand
- ❑ one hand, all fingers
- ❑ one hand, isolating one finger
- ❑ the head, with a mouth stick
- ❑ the nose
- ❑ the feet or toes
- ❑ other – describe: ______________________________

Does the client know the location of the keys? ❑ Yes ❑ No
Has the client had instruction in touch-typing? ❑ Yes ❑ No

❑ Switch access Type of switch ________________________
Switch site ________________________________________
Single switch with scanning? ❑ Yes ❑ No
Scanning software ___________________________________

❑ Voice recognition
Name of program ____________________________________

❑ Other – please describe: ______________________________

Please list input methods the client has tried that were not successful and briefly explain why they are no longer used:

______________________________________________________________

______________________________________________________________

______________________________________________________________

Additional comments:

# *Referral Information*

Who referred the client to the CAT? ______________________________

Contact at referral source:

Name ______________________ Phone ______________________

Who completed this form? (Provide name and relationship to client.)

______________________________________________

Whom should we contact to schedule an evaluation appointment?

Name | Phone

Parent(s) ______________________________

Counselor ______________________________

Teacher ______________________________

Other ______________________________
(Specify profession or relationship to client)

Who will pay for the evaluation?

- ❑ Client
- ❑ Client's family
- ❑ BRS
- ❑ BESB
- ❑ School
- ❑ Other

Authorization to bill for evaluation:

______________________ ______________________
print name signature

Send invoice to:

______________________
______________________
______________________

Send report to:

______________________
______________________
______________________

Who will purchase the recommended equipment and/or training?

- ❑ Client
- ❑ Client's family
- ❑ Agency
- ❑ School
- ❑ Other
- ❑ Undetermined

Return completed form to:

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Southern Connecticut State University
501 Crescent Street
New Haven, CT 06515
FAX: 203-392-5796