

Multnomah ESD AT/AAC Evaluation Referral Form

**Student Name:** Birthdate: Age:

Student Address: City: Zip code:

**Parent / Guardian Name:** Home phone: Work phone:

Preferred method of contact: Phone Email (If email, please provide address below):

School: Teacher: Grade:

Resident School District: IEP Y / N or 504 Y / N

AT mins on IEP? Y / N

**Service requested:**

AT/AAC Evaluation and Recommendations Report

* + Written parent/guardian permission required
	+ Baseline collection/SETT meeting with team input
	+ Trials and data collection of equipment at school
	+ Evaluations may require more than 60 school days- delays to the assessment will be communicated with the IEP team in writing
	+ Recommendation report will be shared with IEP team

Consultation Visit and Report

* + Assess effectiveness of current tool/strategy/approach
	+ Summary of response to intervention data available
	+ Summary of AT/AAC equipment, strategies, tools

**Reason for referral:**

Referring contact Person and email address:

Signature of Authorized Special Ed. School District Official Date