BelieveAbility

PO Box 325
Torrance, CA 90507
310.295.1024 phone/fax
info@believeability.com

Assistive Technology –Referral Information Form

Client's Name _____ Date of Birth _____ Gender ___

Parent/Guardian _____ Home Phone # ( ) _____

Home Address _____ Work Phone # ( ) _____

_____ Email _____

School/Work _____ Grade _____

Address _____ Phone # ( ) _____

_____ District _____

Contact
(case carrier) _____ Phone # ( ) _____

Client's Primary Language _____ Secondary Language _____

Purpose of Referral/Consultation
☐Screening ☐Setup/Training ☐Technical Support ☐Assessment ☐Other _____

Disability (check all that apply)
☐Speech/Language ☐Significant Developmental Delay ☐Specific Learning Disability
☐Cognitive Disability ☐Other Health Impairment ☐Emotional/Behavioral Disability
☐Traumatic Brain Injury ☐Autism ☐Vision Impairment ☐Hearing Impairment
☐Orthopedic Impairment – Type _____
☐Other _____

Assistive Technology - currently used, tried or to be considered

_____

Referral Question ***(required)***
What task(s) does the client need to do that is currently difficult or impossible, for which assistive technology may be an option?

_____

_____

_____ ( ) _____
Requested by Date Phone #

Confidential

Submit by Email