MATCH Team Assistive Technology Referral

Medical Management and Assistive Technology for Children
175 Martin St. Room 227/ Rochester 14605

Today's Date:

Referral Type (Check One)

☐ **Assistive Technology** ☐ **Augmentative & Alternative Communication**

Identification:

Student's Name: **ID#:** **School:**
☐ **IEP** ☐ **504** (include a current copy) ☐ **General Education**
DOB: **Age:**
Grade: **Current Program:** **Class size: (Student to Adult Ratio)**
Person Making Referral (if different than CRT) **Phone:**
CRT: **Phone:**
Parent's Name: **Phone:**
Date Parent was contacted concerning this referral: **By Whom?**
Is there a pending CSE meeting? ☐ **yes** ☐ **no** **If yes when?**

Reason for Referral

What specific classroom task(s) must the student complete that is (are) currently difficult or impossible? Please consider those academic tasks expected by all students in classroom.

Additional Valuable Information

1. Are there any behaviors (both positive and negative) that significantly impact the student's performance?
2. Do you anticipate the student's placement will be changing next year?
3. Please provide any additional comments that will be useful to the MATCH Team staff as they begin the student's assessment?
4. Please provide the AIS or RtI plan that has been developed for this student.

Please submit the completed form to MATCH Team at 175 Martin St. Room 227, Rochester, NY 14605 or email to Wendy Verstringhe at wendy.verstringhe@rcsdk12.org

Date Referral Received: