

SERVICE REFERRAL FORM

Name/Position:		Date:
School Contact Person (if different) & Address:		Additional Contact Person:
School and District:	Student/Classroom:	Phone Number: Fax Number:
Parent/Guardian Name:	Address:	Phone Number:

Please Choose From the Following Menu of Services

<input type="checkbox"/> Assistive Technology Evaluation <i>Most assessments are billed at \$85 an hour for member districts and \$106 an hour for non member districts</i>	
Target Date:	

<input type="checkbox"/> CONSULTATION <i>Most assessments are billed at \$85 an hour for member districts and \$106 an hour for non member districts</i>	
Consultee: (Check all that apply)	
<input type="checkbox"/>	Team meeting
<input type="checkbox"/>	Parent Consultation/Training
<input type="checkbox"/>	Student/Classroom Consultation/Training
<input type="checkbox"/>	TEAM consultation
<input type="checkbox"/>	Other:
Target Date:	
Estimated Hours:	

<input type="checkbox"/> TRAINING & WORKSHOPS (Please describe training requested, how many will attend, and how many hours you are requesting) <i>Training & Workshops are billed at \$85 an hour for member districts and \$106 an hour for non member districts</i>	
Topic:	
Target Date:	
Estimated Hours:	

Please submit applicable documents

- Individual Education Plan (IEP)
- Parent Consent
- Student Schedule
- Previous AT Reports
- Completed Assessments/Reports
 (Including Neuropsychological)

_____ Date: ____/____/_____
 Special Education Director

**For Member Districts, travel will be billed at \$30 per hour.
 For non-member districts, travel will be billed at the hourly rate**