



Special Education Technology Center  
Central Washington University  
400 East University Way Ellensburg, WA 98926-7413  
[www.specialedtechcenter.org](http://www.specialedtechcenter.org)  
(509) 963-3350  
FAX: 509-963-3355

Dear Applicant:

Enclosed is the consultation packet that you requested. Our packet consists of the following:

1. Cover letter explaining our consultation process
2. Consultation packet
3. Videotape Planning Worksheet

**Instructions for completion and submission of the consultation packet are on Page 2 of the packet.** After we have received your completed application and videotape, we will contact you to arrange for the consultation date and time. At this time we will also discuss the consultation options and select the format most suitable to your needs. Consultation options include face-to-face consulting, videoconference, and telephone consultation.

**The Process:**

The videotape you provide will be viewed during the consultation as a frame of reference for technology and teaching strategies that are discussed. **The focus of a consultation is technology planning as it relates to a student's school program including communication, physical access, and academics.** This process involves demonstrations and discussions of technology for current and future use.

**The consultation differs from an "assessment" in that the focus is on sharing a wide range of technology information rather than a one-time trial or "hands-on" assessment of a student's skills.** Information shared by team members and family will determine what technology is suggested for the student. We have found that your experience with the student, over time and in a variety of settings, is more useful than having the student try out equipment in an unfamiliar setting.

**Only occasionally are students involved in the consultation process. Generally, team members and parents can participate best without the student being present.** After the consultation, items from our lending library can be borrowed as a means for conducting these technology trials in an environment familiar to the student. Students of transition age (14 years and older) are welcome as a member of the school team if they are capable of making a contribution to the consultation process.

Note: An exception to the above procedure occurs when our team feels we can be of assistance in identifying a good access method, such as adaptive switch site locations for severely meteorically handicapped students or when a student needs to try out a specific technology that cannot be sent to the student's school. In these cases, we may ask you to arrange for the student to attend the consultation.

At the consultation, note-taking forms will be made available to the school team. If you are not attending a face-to-face consultation, please download the note-taking form and vendor list from our website. (The link is under the "Consultation" heading.) The team is encouraged to take good notes since *the SETC staff will write no formal report*. We will maintain a file on your student containing your application materials and our notes from the meeting until your student reaches 21 years of age.

You will receive a follow-up phone call or email from one of our staff members approximately two months after the consultation to discuss how you are doing with implementing the suggestions that were offered at the consultation and to see if we can be of further assistance. Our staff is available for consultation at any time by email or telephone.

**University faculty and students may view consultations. If this is a problem for any reason, please let us know.**

Sincerely,

**SETC Staff:**

Jerry Connolly, Director  
Kristin Leslie, MS, OTR/L  
Brenda DelMonte, SLP, AT Facilitator  
Barb Lark, AAC Specialist  
Linda Doehle, AT Specialist  
Cathy Hoesterey, OTR/L. AT Specialist  
Sue Wright, Program Coordinator

Enclosures



# Consultation Packet

**Student's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
**School District:** \_\_\_\_\_ **ESD:** \_\_\_\_\_

**School Student Attends:** \_\_\_\_\_

## PRIMARY CONTACT INFORMATION:

(Arrangements for the consultation will be made with this person. The contact person is responsible for contacting the team members and sharing the information provided by the Special Education Technology Center.)

**Name of Primary Contact:** \_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

(Numbers where team can be reached at the last minute in the event the consultation has to be rescheduled due to weather or illness.)

**Mailing address: (If there is a PO Box please list it.)**

**Building:** \_\_\_\_\_

**PO Box or Street Address:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_

## OFFICE USE ONLY

**Date received:** \_\_\_\_\_ **Student ID #:** \_\_\_\_\_

**Date sent for scheduling:** \_\_\_\_\_

**Date sent to staff members:** \_\_\_\_\_ **SETC Staff:** **Bob** **Julie** **Other:** \_\_\_\_\_

## INSTRUCTIONS FOR COMPLETION OF PACKET

1. Meet as a team, including the family, to discuss the student and fill out the packet. (Avoid having the family or staff solely responsible for completion of the packet.)
2. Read through the cover letter and videotape instructions.
3. Complete the packet using a pen with dark ink that will photocopy well.  
**Do not use a pencil.**
4. Make certain all questions are answered and mark NA for those questions not applicable to the student. It may not be necessary to fill out every section of the packet for your student. Note the instructions at the beginning of each section.
5. Include any relevant reports or other materials which you feel will be helpful for our staff.
6. Also include a form from your district authorizing an exchange of confidential information with the Special Education Technology Center.
7. Keep a copy of the packet and the videotape for your records.
8. **Send 3 copies (*the original and 2 copies*) of the completed packet (including all supporting documents) with the videotape to:**

**Special Education Technology Center  
Central Washington University  
400 East University Way  
Ellensburg, WA 98926-7413  
Phone: 509-963-3350  
FAX: 509-963-3355**

## SECTION 1: THE STUDENT - GENERAL

THIS SECTION MUST BE FILLED OUT FOR ALL STUDENTS

**Q1.1 Student's name:** \_\_\_\_\_

**Q1.2 Birthdate:** \_\_\_\_\_ **Q1.3 Grade:** \_\_\_\_\_

**Handicapping condition(s)/official education/medical diagnosis: Check all that apply.**

- |  |   |
|--|---|
| <input type="checkbox"/> Mental retardation: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe<br><input type="checkbox"/> Orthopedically impaired<br><input type="checkbox"/> Vision impaired<br><input type="checkbox"/> Hearing impaired<br><input type="checkbox"/> Other health impaired<br><input type="checkbox"/> Cerebral Palsy<br><input type="checkbox"/> Head injured<br><input type="checkbox"/> Muscular Dystrophy<br><input type="checkbox"/> Other syndromes—please name _____ | <input type="checkbox"/> Autism<br><input type="checkbox"/> Behavior disordered/Emotionally disturbed<br><input type="checkbox"/> ADD/ADHD<br><input type="checkbox"/> LD |
|--|---|

**Anticipated course of condition:**

- Stable  
 Improving  
 Deteriorating

**Are there other disabilities suspected but officially undiagnosed? Please list (e.g., Autism, unknown syndrome, retardation, ataxia, paresis, apraxia, etc.)**

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**Current classroom placement: Check all that apply.**

- Self contained  
 Fully included  
 Partially included  
 Resource  
 Other: \_\_\_\_\_

**Current services received by student and how often: Check all that apply.**

Type	How Often
<input type="checkbox"/> OT	
<input type="checkbox"/> SLP	
<input type="checkbox"/> PT	
<input type="checkbox"/> Vision	
<input type="checkbox"/> Hearing	
<input type="checkbox"/> Other	

**What leisure activities does the student enjoy?**

At home: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In the community: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING QUESTIONS FOR STUDENTS 14 YEARS OR OLDER**

**Is post secondary education a realistic option?**

Yes             No

If yes,  college/university  
 community college  
 vocational-technical institute  
 other: \_\_\_\_\_  
\_\_\_\_\_

**Vocational goal: Check all that may apply.**

competitive employment (independent)  
 competitive employment (supported)  
 enclave  
 sheltered employment  
 other: \_\_\_\_\_  
\_\_\_\_\_

**Probable living situation:**

independent  
 supported  
 family or group home

## SECTION 2: THE TEAM/CLASSROOM

**THIS SECTION MUST BE FILLED OUT FOR ALL STUDENTS**

**How often are team meetings held regarding this student?**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> once a week     | <input type="checkbox"/> once per quarter    | <input type="checkbox"/> less than once per month, more than once per quarter |
| <input type="checkbox"/> twice per month | <input type="checkbox"/> once per year (IEP) |   |
| <input type="checkbox"/> once a month    | <input type="checkbox"/> as needed           |   |

**Who attends?**

Position	Name (Email)
<input type="checkbox"/> Audiologist	
<input type="checkbox"/> Administrator	
<input type="checkbox"/> GENED Teacher	
<input type="checkbox"/> OT	
<input type="checkbox"/> Parapro	
<input type="checkbox"/> Family	
<input type="checkbox"/> PT	
<input type="checkbox"/> Preschool Teacher	
<input type="checkbox"/> Principal	
<input type="checkbox"/> Counselor	
<input type="checkbox"/> Psychologist	
<input type="checkbox"/> SPED Teacher	
<input type="checkbox"/> SLP	
<input type="checkbox"/> Teacher of Deaf	
<input type="checkbox"/> Tech Spec.	
<input type="checkbox"/> Trans Spec.	
<input type="checkbox"/> Vision Spec.	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	

**Consultation goals/concerns: (What product/result do you expect from this consultation?)**

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**If it is determined that a consultation is to be conducted at the Special Education Technology Center, who will be released to attend? (We strongly recommend the entire team.)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Audiologist   | <input type="checkbox"/> Preschool Teacher | <input type="checkbox"/> Tech Spec.     |
| <input type="checkbox"/> Administrator | <input type="checkbox"/> Principal         | <input type="checkbox"/> Trans Spec.    |
| <input type="checkbox"/> GENED Teacher | <input type="checkbox"/> Counselor         | <input type="checkbox"/> Vision Spec.   |
| <input type="checkbox"/> OT            | <input type="checkbox"/> Psychologist      | <input type="checkbox"/> Other 1: _____ |
| <input type="checkbox"/> Parapro       | <input type="checkbox"/> SPED Teacher      | <input type="checkbox"/> Other 2: _____ |
| <input type="checkbox"/> Family        | <input type="checkbox"/> SLP               | <input type="checkbox"/> Other 3: _____ |
| <input type="checkbox"/> PT            | <input type="checkbox"/> Teacher of Deaf   |   |

**Have any of the following agencies assessed or evaluated this student within the past 12 months? Describe what type of assessment resulted.**

Facility	Type of Assessment	Date
<input type="checkbox"/> Children's Hospital and Medical Center (Seattle, WA)		
<input type="checkbox"/> Child Development and Rehabilitation Center (Portland, OR)		
<input type="checkbox"/> Another Hospital:		
<input type="checkbox"/> Private evaluation: Person/agency name:		
<input type="checkbox"/> University organization:		
<input type="checkbox"/> Other:		

**Is another agency presently involved with this student?**

Yes             No             NA

**If so, please list their name and give a description of the services they provide for the student.**

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**What is the staff experience with this student's handicapping condition?**

- None
- Minimal
- Moderate
- Lots
- Only one staff member is familiar
- Itinerant staff has had most of the experience

**Our team**

- is **very** familiar with a **wide range** of technology
- is **somewhat** familiar with a wide range of technology
- is familiar with a **narrow range** of technology (specify) \_\_\_\_\_
- is just starting to use technology (specify) \_\_\_\_\_
- has 1 or 2 members who are sort of "techie" (list names) \_\_\_\_\_
- is generally familiar with older and dated technology
- is totally new at using technology and is generally unfamiliar with it



## SECTION 3: THE STUDENT'S FUNCTIONING LEVELS

THIS SECTION MUST BE FILLED OUT FOR ALL STUDENTS

Please describe the individual's present capabilities and/or limitations in the following areas. If a significant limitation exists in any of the areas, please attach relevant reports/assessments.

### 1. Cognitive:

Understands cause and effect

Student demonstrates awareness of objects by:

searching with eyes

searching physically

verbalizing

Student can sequence series of items

Student can recall a sequence of items

Student attends to a task for \_\_\_\_\_ minutes

Student processes and responds to information:

at an average rate

with additional thinking time

with repetition of instruction

with repeated practice

with multiple methods of presentation

In the area of problem solving, student:

invents new strategies

is independent

asks for help

waits passively for help

acts impulsively

is prompt dependent

lacks awareness of problem

Does student generalize skills?

yes

no

Other (please specify): \_\_\_\_\_

### 2. Vision:

Student's vision appears normal:  yes  no **If no, complete the following questions in this section.**

Describe student's vision with correction and without (in layman's terms).

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Student can:  visually track  visually sequence  understand spatial relationships

List visual requirements (color, contrast, etc.):

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What size picture can student see effectively and at what distance?

Has student had a functional vision assessment?  yes  no

If yes: Date of assessment: \_\_\_\_\_ By whom: \_\_\_\_\_

**3. Hearing:**

Student's hearing appears normal:  yes  no **If no, complete the following questions in this section.**

Describe student's hearing: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of student's last hearing assessment: \_\_\_\_\_ By whom: \_\_\_\_\_

Does student have a need for sign language?  yes  no

**4. General health:**

Has restrictions or special requirements for drinking or feeding.

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has seizures. List type and significant side effects.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Takes medications with significant side effects. List effects.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you expect any of the above to change in the next 5 years? How?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING QUESTIONS FOR STUDENTS WITH ACADEMIC NEEDS**

**5. Reading grade levels:**

Decoding: \_\_\_\_\_ Comprehension: \_\_\_\_\_

Reading approach used (phonics, basal, whole language, etc.): \_\_\_\_\_

\_\_\_\_\_

Problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**6. Written language:**

How does the student most effectively express him/herself in written form? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

[ ] We haven't found an effective means for this student to express him/herself in written form.

If applicable, how long would it take him/her to write a 25 word paragraph using the above method? \_\_\_\_\_

What is the student's grade level in spelling? \_\_\_\_\_

**7. Math Skills:**

Describe the student's current level of functioning in math.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How does he/she demonstrate understanding of math concepts? (specify use of paper/pencil, manipulatives, calculator, oral response, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

[ ] We haven't found an effective means for this student to express his/her understanding of math concepts.

## SECTION 4: PHYSICAL ACCESS TO TECHNOLOGY

COMPLETE PAGES 10-11 FOR STUDENTS WITH PHYSICAL ACCESS NEEDS

1. **Hand preference:**       right       left

2. **The student can:**

- |   |  |
|---|--|
| <input type="checkbox"/> grasp/release objects                  | <input type="checkbox"/> maintain switch closure |
| <input type="checkbox"/> cross midline                          | <input type="checkbox"/> point with 1-2 fingers  |
| <input type="checkbox"/> point with whole hand                  | <input type="checkbox"/> write with a pen/pencil |
| <input type="checkbox"/> maintain accurate point (no athetosis) | <input type="checkbox"/> type                    |

3. **Describe student's physical movement, positioning, dexterity, range, strength, dependability (in layman's terms). Include smallest area student can accurately point and widest range of access.**

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4. **Please indicate all equipment currently used in the areas of:**

feeding: \_\_\_\_\_

seating/positioning: \_\_\_\_\_

other: \_\_\_\_\_

5. **Has a switch assessment ever been completed?**  yes     no

If yes: Date of assessment: \_\_\_\_\_ By whom: \_\_\_\_\_

What were the results? \_\_\_\_\_

**6. Check the switches that have been tried with the student. Indicate whether the student was:**

**1 = Very successful**

**2 = Somewhat successful**

**3 = Not successful**

	<b>1</b>	<b>2</b>	<b>3</b>		<b>1</b>	<b>2</b>	<b>3</b>
<input type="checkbox"/> BASS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pal Pad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Big Red	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Plate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Buddy Button	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Proximity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ellipse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sound sensor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Grip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sip/Puff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Infrared sensor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Specs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Jelly Bean	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> String	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Joggle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Treadle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leaf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Twitch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Light touch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ultimate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Motion sensor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Wobble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other (specify): _____				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

**7. Check the switch access methods that have been tried with the student and note right or left where appropriate. Indicate whether the student was:**

**1 = Very successful**

**2 = Somewhat successful**

**3 = Not successful**

	<b>Right</b>	<b>Left</b>	<b>1</b>	<b>2</b>	<b>3</b>
<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cheek	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Forearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thigh/Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify): _____

**8. Check the environmental control technologies that have been tried with the student. Indicate whether the student was:**

**1 = Very successful**

**2 = Somewhat successful**

**3 = Not successful**

	<b>1</b>	<b>2</b>	<b>3</b>
<input type="checkbox"/> PowerLink	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cordless Big Switch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wireless Pal Pad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> TASH Ultra 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> X-10 system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (specify): _____

## SECTION 5: COMPUTER ACCESS

COMPLETE PAGES 12-13 FOR STUDENTS WITH COMPUTER ACCESS NEEDS

**1. Are there software programs or tasks that you would like the student to be able to use but that he/she is unable to use because of computer access limitations?**      yes                     no

If yes, please name those programs or tasks: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**2. Check the computer platform that the student will be using:**

- a. in the current school environment:      Apple II      Macintosh      Windows
- b. in a future school environment:      Apple II      Macintosh      Windows
- c. at home:      Apple II      Macintosh      Windows

**3. Check the computer access technologies that have been tried with the student. Indicate whether the student was:**

**1 = Very successful            2 = Somewhat successful            3 = Not successful**

**HARDWARE:**

	<b>1</b>	<b>2</b>	<b>3</b>
<input type="checkbox"/> Switch Interface	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Discover:Switch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Discover:Board	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> IntelliKeys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mini Keyboard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Touch Window (or other touchscreen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Trackball	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Joystick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Touchpad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> HeadMouse or Tracker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**1 = Very successful**

**2 = Somewhat successful**

**3 = Not successful**

**SWITCH ACCESSIBLE SOFTWARE (list by name):**

	<b>1</b>	<b>2</b>	<b>3</b>
[ ] _____	[ ]	[ ]	[ ]
[ ] _____	[ ]	[ ]	[ ]
[ ] _____	[ ]	[ ]	[ ]
[ ] _____	[ ]	[ ]	[ ]

**ON-SCREEN KEYBOARDS (list by name):**

	<b>1</b>	<b>2</b>	<b>3</b>
[ ] _____	[ ]	[ ]	[ ]
[ ] _____	[ ]	[ ]	[ ]

**SCREEN READER (list by name):**

	<b>1</b>	<b>2</b>	<b>3</b>
[ ] _____	[ ]	[ ]	[ ]

**SCREEN ENLARGEMENT (list by name):**

	<b>1</b>	<b>2</b>	<b>3</b>
[ ] _____	[ ]	[ ]	[ ]

**OTHER (list by name):**

	<b>1</b>	<b>2</b>	<b>3</b>
[ ] _____	[ ]	[ ]	[ ]
[ ] _____	[ ]	[ ]	[ ]

## SECTION 6: WRITTEN LANGUAGE

COMPLETE THIS PAGE FOR STUDENTS WHO NEED ACCESS TO WORD PROCESSING

1. Is the student capable of typing on a regular keyboard?     yes                       no

If yes, how would you describe the student's approach to typing?

- One finger
- Hunt and peck using multiple fingers
- One handed touch typing
- Two handed touch typing

2. Which word processing software has the student used? \_\_\_\_\_

\_\_\_\_\_

What was the result? \_\_\_\_\_

3. Has the student tried word prediction software?     yes                       no

If yes, which product was used? \_\_\_\_\_

What was the result? \_\_\_\_\_

4. Has the student tried a dedicated portable word processing device such as an AlphaSmart Keyboard, Dreamwriter, LaserPC5, eMate, etc.?     yes                       no

If yes, which device was used? \_\_\_\_\_

What was the result? \_\_\_\_\_

5. Has the student tried speech recognition software?     yes                       no

If yes, which product was tried? \_\_\_\_\_

What was the result? \_\_\_\_\_

6. Has the student tried an alternate keyboard for word processing?     yes                       no

If yes, which device was used? \_\_\_\_\_

What was the result? \_\_\_\_\_



## SECTION 7: COMMUNICATION

COMPLETE PAGES 15-17 FOR STUDENTS WHO NEED ASSISTANCE/ALTERNATIVES IN ORAL COMMUNICATION

1. Describe, in general, how the student currently communicates. Please include meaningful behaviors in your description.

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2. What objects/activities will motivate the student to communicate?

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3. Please answer the following regarding the student's current communication level. Check any of the following that apply in each section.

**Student's current expressive communication system:**

- Oral  
     Less than 50% intelligible to unfamiliar partners  
     Less than 25% intelligible to unfamiliar partners  
 Gestures  
 Sign Language  
    \_\_\_\_\_ # of signs student uses **spontaneously**  
 Picture board or PECS

**Estimated student receptive level:**

- Unable to assess formally

Assessment tool used: \_\_\_\_\_

- Within 1 year of CA  
 Less than 50% of CA

**Please check your responses to the following questions:**

<b>Student can:</b>	<b>Yes</b>	<b>No</b>
Follow verbal classroom instructions	<input type="checkbox"/>	<input type="checkbox"/>
Make basic needs and wants known	<input type="checkbox"/>	<input type="checkbox"/>
Communicate academic understanding	<input type="checkbox"/>	<input type="checkbox"/>
Initiate communication with adults	<input type="checkbox"/>	<input type="checkbox"/>
Initiate communication with peers	<input type="checkbox"/>	<input type="checkbox"/>

**4. Check or list all forms of communication currently used by the student. Within each major heading (i.e., gestures, speech, etc.) indicate whether student:**

**1 = Tried with little success      2 = Is successful at least somewhat      3 = Is very successful**

**GESTURES:**

	<b>1</b>	<b>2</b>	<b>3</b>
<input type="checkbox"/> Facial expressions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Whole body gestures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Conventional gestures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gestural yes/no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eye point	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sign language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Give for help gesture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SPEECH:**

	<b>1</b>	<b>2</b>	<b>3</b>
<input type="checkbox"/> Vocalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spoken yes/no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Short phrases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Uses connected speech but is only _____% understandable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MANUAL COMMUNICATION BOARD:**

	<b>1</b>	<b>2</b>	<b>3</b>
<input type="checkbox"/> Photos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Single pictures (line drawings)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sequencing pictures to communicate in sentences/phrases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MANUAL SIGNING:**

	<b>1</b>	<b>2</b>	<b>3</b>
<input type="checkbox"/> Single adapted signs with prompt _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spontaneous adapted single signs without a prompt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Regular unadapted single signs without a prompt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 1–2 connected regular signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 2 or more connected regular signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**OTHER:**

	<b>1</b>	<b>2</b>	<b>3</b>
<input type="checkbox"/> Object cues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Object or picture calendar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Simple choice making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eye pointing system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Written text	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Electronic device (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**AUGMENTATIVE COMMUNICATION TECHNOLOGY (specify device used):**

	<b>1</b>	<b>2</b>	<b>3</b>
Device name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Device name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Device name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Device name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**5. Indicate ADULT communication that is likely to elicit student response.**

**NONVERBAL:**

- gestures
- line drawings
- photographs
- sign language
- object cues
- words + gestures
- undetermined
- a combination of above

**VERBAL:**

- does not understand spoken words
- understands single words
- understands simple phrases
- understands conversation
- understands adult humor and idiomatic language
- needs visual cues paired with one of the above

**6. What are the student's potential message needs within the next three years? (Check all that apply.)**

- call attention
- answer yes/no questions
- make simple choices
- greet people
- signal emergencies
- express emotions
- confirm/reject
- initiate an interaction
- make requests
- converse
- repair communication breakdown
- give opinions
- clarify speech
- provide unique information
- other (specify): \_\_\_\_\_



THIS PAGE FOR PARENT/LEGAL GUARDIAN TO COMPLETE

## Permission for Videotaping and Observation

I, \_\_\_\_\_, as parent or legal guardian of \_\_\_\_\_, grant permission to the Special Education Technology Center to do the following during the scheduled consultation at the Special Education Technology Center or as a result of the consultation:

### CHECK THE FOLLOWING

- | YES                      | NO                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | To videotape my child while attending the consultation                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | To use pre-taped video footage of my child during the consultation                      |
| <input type="checkbox"/> | <input type="checkbox"/> | To use video footage of my child for purposes of educator training or staff development |
| <input type="checkbox"/> | <input type="checkbox"/> | University faculty and staff may observe this consultation process                      |

I, the undersigned, understand that by giving permission for the Special Education Technology Center to use video footage of my child, that said videotape becomes the property of the Special Education Technology Center and will be used for educational purposes only.

Parent/Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_