



**Greene County Assistive Technology (AT) /Augmentative and Alternative  
Communication (AAC) Consultation  
Referral Form**

**Student Information**

Student Name: \_\_\_\_\_

Student Birthdate: \_\_\_\_\_

Student Grade: \_\_\_\_\_

School District: \_\_\_\_\_

School Building: \_\_\_\_\_

Point of contact for scheduling meetings: \_\_\_\_\_

**Student's Educational Team**

Teacher: \_\_\_\_\_

Speech/language: \_\_\_\_\_

Occupational Therapist: \_\_\_\_\_

Physical Therapist: \_\_\_\_\_

Paraprofessional(s): \_\_\_\_\_

School-based Mental Health Therapist: \_\_\_\_\_

Any other agencies or private professionals involved:

\_\_\_\_\_

Best times of day to meet: \_\_\_\_\_

**Referral information**

Reason for referral:

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Brief description of communication skill levels and current concerns:

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Is student on a RTI Plan, 504 plan or IEP?

- Yes
- No

Please attach/send the following documents:

- Evaluation Team Reports, RTI Plan, IEP or 504 if applicable, Functional Communication Inventories, detailed description of communication skill levels and concerns if available
- District Release of information
- Parent permission

By signing below, the referring superintendent/designee with authority to commit district resources is providing consent for ongoing behavior coaching services for this student:

Signature: \_\_\_\_\_

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

( return completed form to [Lburger@greeneesc.org](mailto:Lburger@greeneesc.org) )