



Request for Consultation on Assistive Technology Solutions
Philadelphia Infant Toddler Early Intervention

The purpose of technical assistance ("TA") in assistive technology ("AT") is to help the child's family and team members consider assistive technology as one way to help reach the desired outcomes. It is also meant to build the capacity of the professionals on the team by increasing their knowledge, skill, and comfort levels in identifying and implementing assistive technology solutions. This is not a "formal" evaluation of the child. For questions about this service, please contact the Institute on Disabilities.

Complete and return this form to:

Meng McLendon, MS, CCC-SLP
Augmentative & Alternative
Communication Services Coordinator
Phone: 215-204-6560
E-mail: meng.mclendon@temple.edu

Institute on Disabilities at Temple University
Attn: Meng McLendon, MS, CCC-SLP
1301 Cecil B. Moore Avenue
Ritter Annex 4, Room RA 430
Philadelphia, PA 19122

Date of Request: _____ / _____ / _____

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Child's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street Address Apt Number

Philadelphia, PA \_\_\_\_\_  
ZIP Code Special Instructions for Finding or Parking at the Home

Parent's Phone: \_\_\_\_\_ - \_\_\_\_\_ Other Phone: \_\_\_\_\_ - \_\_\_\_\_

Parent's E-mail: \_\_\_\_\_

Does the family speak English as the primary language in the home?  Yes  No

If not, please list other language(s) spoken: \_\_\_\_\_

NOTE: The child's team is responsible for providing needed language supports, including translating the written report. Team members should coordinate so an interpreter is present during the visit.

Person Requesting TA for AT: \_\_\_\_\_

Role & Agency: \_\_\_\_\_

Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_

Service Coordinator: \_\_\_\_\_

Agency Address & Fax: \_\_\_\_\_

Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_

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1. Are any assistive technology (AT) devices or services currently listed on the child's IFSP?
 No Yes. *If yes, describe in space below (or attach copy of relevant IFSP pages).*
2. Does the child have and USE any AT now (other than is listed above or in IFSP)?
 No Yes. *If yes, describe in space below.*
3. Has any AT been used in the past?
 No Yes. *If yes, describe in space below.*

Describe the past/current experiences with AT devices and services (from Questions 1-3).
~ NOTE: Assistive technology devices include specialized items (like bath chair, KidKart; adapted toy)
AND "generic" items (like Boppy pillow used for positioning, grips or handles on sippy cup).
AT services include assessment (e.g. seating / positioning evaluation), customization, and training. ~

4. What services are currently listed on the child's IFSP? (Check all that apply)
If known, provide the professional's name, phone, and/or e-mail.
- Special Instruction (from SI or TAACT) _____
- Speech-Language Therapy (from SLP) _____
- Feeding / Swallowing Therapy (from SLP) _____

- Occupational Therapy _____
- Physical Therapy _____
- Hearing Therapy _____
- Vision Therapy (from VI) _____
- Other: _____

5. In what functional skill areas might AT be helpful? (check all that apply)

- Interaction with materials (e.g., controlling, touching, handling, seeing, accessing toys)
- Movement (e.g. seating, positioning, moving)
- Using hands (e. g. pointing, grasping, pulling)
- Communication (e.g. speaking, hearing, interacting with others)
- Other: _____

6. What are (child or family) outcomes that the team expects AT might help achieve? Which activities or routines do you hope the child will be able to participate in with AT?

(For Example: have safe / supported bath time; effectively transition to bedtime; increase independence during mealtime; interact with toys for successful "play time" with siblings; participate in community activities like park, playground, grocery store, etc.)

Are these goals currently listed on the child's IFSP? No Yes

7. What does the team expect as outcomes from the technical assistance visit?

8. Please note other information (including relevant medical diagnoses) that you think it will be useful for the AT provider to have prior to seeing this child/family.

9. List options for times and days of the week for scheduling. It is preferred that at least two relevant team members, in addition to the parent, can attend.

Scheduling options: _____

10. Is this the first child you have referred for Technical Assistance in AT?

No, this is not the first child I have referred. I have previously referred

___ 1 child ___ 2-3 children ___ more than 4 children

Yes, this is the first child I have referred, because (check all that apply)

___ This is my first year as an EI provider.

___ I never heard of the availability of this service before.

___ I never had a child on my caseload that I thought would be appropriate for AT.

___ I have comprehensive skills/expertise in AT. I've been able to address past AT needs myself.

___ It should be the responsibility of a different team member to refer for this service.

___ I wanted to refer, but the parent did not want the service.

___ Other reason: _____

11. Why are you utilizing Technical Assistance in AT at this time? (check all that apply)

___ I have had previous positive experiences with this service.

___ This child is nearing transition.

___ The child has developed the prerequisite skills to benefit from AT.

(Describe: _____)

___ The child's developmental gap in the area of _____ is now evident (e.g. wasn't speaking, and now is at the age where she SHOULD be speaking).

___ A quarterly review or transition (IFSP→IEP) meeting is coming up soon (Date: ___/___).

___ Other IFSP team members have suggested AT for this child.

___ Parent has suggested AT for this child.

___ AT is an area that I have a lot of interest in and want to develop my skills in this area.

___ Other reason: _____

Thank you! Someone will be in touch with you soon to discuss this request.