Utah Assistive Technology Lab:

Assistive Technology & AT Service Referral Form:

Utah Assistive Technology Program (UATP)
www.uatpat.org

Referring Agent: Please complete as much information as possible (type or write legibly) and fax to 435-797-2355 or email to lois.summers@usu.edu. For questions, call 435-797-0699, ext. 1.

I. Client information: **Date of Referral: _____**

Name:_____ Phone:_____

Street Address:_____ Apt. #:_____ City:_____

State:_____ Zip Code:_____ Email:_____ Age:_____ Gender:_____

Disability(ies):_____ Height (in.):_____ Weight (lbs.):_____

Contact Person (other than client):_____ Phone:_____

Relationship to Client (Circle one): Parent Child Spouse Caregiver Other (Specify):_____

II. A. Type of AT service requested: (mark all that apply)

- ☐ **Activities of Daily Living (ADL)**
- ☐ **Adaptive Computer Software**
- ☐ **Alternative Computer Access**
- ☐ **Augmentative/Alternative Communication**
- ☐ **Blind/Low-vision Assistive Technology**
- ☐ **Educational Assistive Technology**
- ☐ **Job/Home Site Assessment for Accessibility Modifications**
- ☐ **Mobility AT (see 2.B for further info)**
- ☐ **Recreational Assistive Technology**
- ☐ **Transportation/Vehicle Hand Controls**
- ☐ **Vocational Assistive Technology**
- ☐ **Other AT (specify):_____**

B. Mobility AT (Circle one): Wheeled Mobility Seating & Positioning Other Mobility:_____

III. Purpose of referral (be specific, include functional limitations & vocational or independent living goals):

_____
_____
_____

IV. Other information that could be helpful to the AT assessment process:

_____
_____
_____

V. Referring agent contact information:

Name:_____ Email:_____ Phone:_____

Agency (if applicable):_____ Office:_____