Assistive Technology Developmental Evaluation of Necessity

Section 1: General Information

Name:	**EI#:**
Date of Evaluation/Assessment:	**Date of Birth:**
Age:	**Adjusted Age:**
Evaluator:	**Discipline:**
Service Coordinator:	
Physician Full Name:	**License #:**
Child is being observed in: _____Home _____Childcare _____Clinic _____Other	

Section 2: IFSP Information

IFSP Begin Date:	**IFSP End Date:**
Medical History (include diagnosis):	
Current Services Provided:	
Functional Outcome That Supports Current Equipment Request:	
Current Progress Toward That Outcome:	
Parent Concerns Related to Outcome:	

Section 3: AT Equipment Requested

Category of AT: **_____Category 1** **_____Category 2** **(requires completion of Section 5)**	**AT Item(s) Requested** (attach catalog photos/pricing not included)**:**

Section 4: Justification

1. Explain how the AT will help facilitate child's participation in the family's daily routines and community activities.
2. Describe how the family (parent/caregiver) will utilize the AT within the child's daily routines/activities.
3. Describe AT currently being utilized. Consider all adaptive supports.
4. Will the requested AT supplement or replace current AT or adaptations? If yes, please describe.

5. Describe how the physical environment supports the use of requested AT.
6. Will additional interventionist training be necessary on the use, care and implementation of the device after the equipment is delivered? If yes, please explain how this will be accomplished.
7. Explain how you will instruct the family/caregiver in fit and use of the requested AT.
8. How will a home activity program be developed with the family to explain how to incorporate the AT within daily routines/activities?

Section 5: Category 2 Additional Justification Required

Current Functional Status (discuss vision, hearing, motor, communication, sensory, mode of access-level/method of assistance needed to use AT)**:**
Assessment and Findings (Include trials of various equipment/devices, height/weight and/or other pertinent measurements)**:**
Recommendations (include any additional components/accessories needed for device):

Signature Date

Printed Name Phone Number

For Physician use only:

By signing this document, the physician agrees with information presented. The signature serves as a prescription for recommended item(s).

Physician Signature Date

Physician Printed Name Phone Number

Physician's NPI# Physician's License #