UCAT ILForm
07-12

UTAH CENTER FOR ASSISTIVE TECHNOLOGY
ASSISTIVE TECHNOLOGY (AT) REFERRAL FORM

Referring Agent: Complete as much information as possible and email to ucat@utah.gov

TYPE OR WRITE LEGIBLY Date of referral:_____

I.(a) Client Contact Information:

Name: _____ Phone: _____

Street Address: _____ Apt #: _____

City: _____ State: ___ Zip Code: _____ E-mail: _____

I.(b) Demographic Information: Ethnicity: _____ Date of birth:_____ Gender:_____

I.(c) Disability(ies) (cause & imp. codes, if avail)**:** _____

I.(d) Contact Person (other than client): _____ Phone: _____ _____

Relationship to Client (mark one): ☐Parent ☐Spouse ☐Child ☐Caregiver ☐Other (specify):_____

II. Type of AT Service Requested: (mark **all** that apply)					
☐	Job- and/or home-site assessment	☐	Activities of Daily Living		
☐	Augmentative Communication	☐	Vehicle Hand Controls		
☐	Educational Assistance Technology	For below services only, please list approx ht & wt			
☐	Alternative Computer Access	☐	Wheeled Mobility	**Height (in)**	**Weight (lb)**
☐	Computer System Recommendation	☐	Other Mobility		
☐	PC Loan (VR clients only)	☐	Seating & Positioning		
☐	Other (Specify): _____				

III. Purpose of Referral (**be specific**; include functional limitations and vocational or independent-living goals):

IV. Other Information That Could Be Helpful to the AT Assessment Process:

V. Referring Agent Contact Information:

Name:_____ E-mail_____ Phone: _____

Agency: _____ Office: _____

Other Agency Involvement (if known): _____

☐ **ILP WAVER FORM SIGNED**