



**The Ohio Center for Deafblind Education
Deafblind Technical Assistance Program (DBTAP)**

Request for Technical Assistance On-Site Consultation

Date: _____

Person Requesting Technical Assistance On-Site Consultation: _____

Title/Relationship to Student: _____ School/Agency (if applicable): _____

Street Address: _____ City, State, and Zip Code: _____

County: _____ Phone Number: _____ Email Address: _____

Do you prefer to be contacted by phone or email? _____

When is the best time to contact you? _____

Student/Child Name: _____ DOB: _____

Briefly describe why you are requesting an on-site consultation: _____

Please list the persons who will be a part of the on-site consultation (name and title): _____

Communication modes used by the student/child to express themselves

(please check all that apply and provide any additional information that may be helpful to the consultant who will be working with you):

- Spoken Language
- Sign Language
- Body Language, Facial Expressions
- Behavior
- Vocalizations
- Touch Cues
- Object Cues
- Picture Cues
- Print
- Braille
- Augmentative Devices
- Assistive Technology
- Other

Comments: _____

Communication modes used by individuals to communicate with the child/student

(please check all that apply and provide any additional information that may be helpful to the consult who will be working with you):

- Spoken Language
- Sign Language
- Body Language, Facial Expressions
- Behavior
- Vocalizations
- Touch Cues
- Object Cues
- Picture Cues
- Print
- Braille
- Augmentative Devices
- Assistive Technology
- Other

Comments: _____

Orientation and Mobility used by the child/student (check all that apply):

- Independently at all times
- Independently in familiar environments with assistance in unfamiliar environments
- Assistance/ sighted guide at all times
- Uses a cane or other adaptive device
- Uses a wheelchair
- Uses a dog guide
- Other

Comments: _____

Self-Help Skills:

Eating:

- Independent Needs Some Assistance Full Assistance

Toileting:

- Independent Needs Some Assistance Full Assistance

Dressing:

- Independent Needs Some Assistance Full Assistance

Bathing/Washing:

- Independent Needs Some Assistance Full Assistance

Oral Hygiene:

- Independent Needs Some Assistance Full Assistance

Care of Hearing Aides, Low Vision Aides:

- Independent Needs Some Assistance Full Assistance

Comments: _____

Related services the student/child is currently receiving:

- | | | |
|-------------------------------------------------------------|-------------------------------------------------|-------------------------------------|
| <input type="checkbox"/> Audiological | <input type="checkbox"/> Transportation | <input type="checkbox"/> Work Study |
| <input type="checkbox"/> Speech/Language | <input type="checkbox"/> Interpreter | <input type="checkbox"/> Aide |
| <input type="checkbox"/> Adapted Physical Education | <input type="checkbox"/> Home-Based Instruction | <input type="checkbox"/> Attendant |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Guide |
| <input type="checkbox"/> Orientation and Mobility | <input type="checkbox"/> Vision Consultation | <input type="checkbox"/> Medical |
| <input type="checkbox"/> Vocational Special Ed. Coordinator | <input type="checkbox"/> School Psychological | <input type="checkbox"/> Reader |
| <input type="checkbox"/> Other (please specify) _____ | | |

Additional agencies currently providing services to the student/child: _____

Please return form and current IEP by fax or mail to:

The Ohio Center for Deafblind Education

Attn: Heather Herbster

2080 Citygate Drive

Columbus, Ohio 43219

FAX: (614) 785-0513

Phone: (800) 229-0844

(614) 785-1163

TTY: (614) 785-1158

Once we receive this information, **along with the signed original copy of the Parent Release Form**, you will be contacted by a DBTAP consultant to discuss the details of your request and to schedule the on-site visit. Thank you.