THE OHIO CENTER FOR

DEAFBLIND EDUCATION

Deafblind Technical Assistance Program (DBTAP)
Request for Technical Assistance On-Site Consultation

Date: ________________________

Person Requesting the Consultation:____

Relationship to Child/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? ____

Child/Student's Name: _____________________________________ DOB: ___________________________

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

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

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Communication modes used by the child/student 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:

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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:

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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:

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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:____

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Related services the child/student is currently receiving:

___ Audiology
___ Speech/Language
___ Adapted Physical Education
___ Physical Therapy
___ Orientation and Mobility
___ Vocational Special Ed. Coordinator
___ Transportation
___ Interpreter
___ Home-Based Instruction
___ Occupational Therapy
___ Vision Consultation
___ School Psychological
___ Work Study
___ Aide
___ Attendant
___ Guide
___ Medical
___ Reader
___ Other (please specify) ____

(OVER)

Please list other agencies that are currently working with the child/student: ______________________________

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Please return form and current IEP by fax or mail to:
The Ohio Center for Deafblind Education
Attn: Outreach Specialist
936 Eastwind Drive
Westerville, Ohio 43081
FAX: (614) 785-0513
Phone: (800) 229-0844
(614) 785-1163
TTY: (614) 785-1158

Please note that the original signed Parent Release form must be returned to OCDBE before services can begin. Once we've received both forms a DBTAP consultant will contact you to discuss the details of your request and to schedule the on-site visit. Thank you.