EASTER SEALS OUTREACH (ESO)

ASSISTANCE REQUEST FORM

DATE: _____

LEA SUPERVISOR/EC COORDINATOR NAME: _____

ADDRESS: _____ PHONE #: _____

EMAIL: _____ FAX #: _____

THIS REQUEST WAS INITIATED BY: _____ TITLE: _____
(Parent, Teacher, OT, SLP, etc.)

STUDENT (if applicable): _____ DOB: _____ AGE: _____

PRIMARY HANDICAPPING CONDITION: _____

SCHOOL: DISTRICT _____

(Please check the appropriate box next to the service being requested)

v	TYPE OF SERVICE REQUESTED	DESCRIPTION OF SERVICE REQUEST
	Student Consultation (Troubleshooting assistance to address needs of individual student)	
	Informal Teacher or Team Consultation (Troubleshooting assistance to address needs of teacher or to collaborate with team)	
	Assistive Technology Training, Equipment Loan, Resource Information (Short term loan of assistive technology, resource books or video tapes and training or troubleshooting in the use of specific AT devices)	
	Psychoeducational Evaluation and Training (Supplementary service to existing school resources; targeted toward capacity-building; district assessment staff must be available to participate; independent assessments are not conducted)	
	Augmentative Communication Evaluation	

In order to determine how best to meet the service needs indicated above, an ESO consultant will call to set up an initial assistance conference. The type of assistance provided will be determined at this conference.

The signatures below signify a commitment to support this initial assistance conference and to ensure the availability of the following personnel (please check) for the conference:

_____ Teacher(s) _____ Paraprofessional _____ Speech/Language Pathologist

_____ Occupational Therapist _____ Physical Therapist _____ Other

_____ LEA Supervisor or Early Childhood Coordinator

_____ School Principal

WHEN COMPLETED, FAX TO BRYAN AYRES AT 501-227-3771