Request for Family and Home Consultation

Name of Person Making Request: ____________________________

Date of Request: ____________________________

TSBVI Outreach offers family members information, support, training and travel assistance in a variety of ways. Please check any of the items below that you would like someone to contact you about. Upon receipt of this request one of our family support specialists will contact you.

Information and Resources

____ Learn more about your child’s disability
____ Learn about the education systems available for my child
____ Learn more about your child’s unique learning needs
____ Participate in training on this topic or subject: ____________________________
____ Other: ____________________________

Connections to Organizations and Other Families

____ Looking for a Family to Family Connection
____ Texas VI Family Listserv
____ Organizations - DBMAT, NTAC, TAPVI, NAPVI
____ Connect with another parent/family (mentoring)

Newsletter

____ Receive the TX SenseAbilities Newsletter

Phone Consultation

I want to talk individually with one of the family support specialists about:

____ my child.
____ my child’s program.
____ resources for my family
____ training for me or my family
____ financial assistance to participate in training events.

____ I am interested in Family Leadership Training.
Home Consultation

Giving us this information will help us to better prepare before contacting you. However, you may always contact us directly by phone or email. Upon receipt of this request one of our family support specialists will contact you as soon as possible.

Who Is Making This Request?

Person Completing Form:

___ Parent
___ Other Family Member
___ Educator
___ State Agency Staff
___ Community Support Professional/Volunteer
___ Other (please specify):

If you are a professional, did you partner with the family in completing this form?

___ Yes
___ No

Please give us your contact information:
Phone: ___________________ Email: ____________________________

Family Contact Information:

Parent(s)/Caregiver(s) Name: ______________________________________
Address: ________________________________________________________
Telephone Numbers: home): ____________ (work): ___________
(cell): ____________ Email: ____________________________

What is the best way to contact you?
___ Phone – if so, which number? ____________________________
___ Email: ________________________________________________

What is the best time to contact you? ________________________________

Tell Us a Little Bit About Your Child:

Name: ________________________________
Age: ____________________ Birth date: ____________________________

In brief, what do you know about his or her vision? (For example, what caused the vision loss and what you think your child can see.)
In brief, what do you know about his or her hearing? (For example, “she has great hearing” or “he has a hearing loss, but I think he hears some very loud sounds”.)

Does your child have deafblindness (both hearing and vision loss, even mild ones)?

___ Yes
___ No

In brief, what do you know about his or her other disabilities and/or medical conditions (if any)?

Tell us about your child’s current educational services:

___ Early Childhood Intervention (ECI)
___ Preschool Program for Children with Disabilities (PPCD)
___ School District: __________________________ grade level if known: ____
___ Private or Charter School Program

Send This Request

Please email or fax (512-206-9320) this form to:

Families of Students with Visual and/or Visual and Multiple Impairments and Spanish-Speaking Parents

Jean Robinson
Visually Impaired Family Support
512-206-9418
jeanrobinson@tsbvi.edu

Families of Students with Deafblindness

Edgenie Bellah
Deafblind Family Support
512-206-9423
bellahe@tsbvi.edu