



# Wisconsin Center for the Blind and Visually Impaired

Elizabeth Burmaster, State Superintendent  
Wisconsin Department of Public Instruction



## OUTREACH SERVICES REQUEST (OSR) FORM

Today's Date \_\_\_\_\_

**Contact Person** \_\_\_\_\_  
Name and Title \_\_\_\_\_ District/ CESA/ B-3 Program employed by \_\_\_\_\_ E-mail address \_\_\_\_\_

Address \_\_\_\_\_ Phone (W) \_\_\_\_\_ (C) \_\_\_\_\_  
 Work  Home Street \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Student's School District \_\_\_\_\_ Student's School \_\_\_\_\_ Grade: \_\_\_\_\_  
(of residence)  High  Middle  Elem  EEN  n/a

**Name of Student:** \_\_\_\_\_  M  F Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Are Vision and O&M services listed on child's current IEP/IFSP?:  
**Vision:** Yes  No  **O&M:** Yes  No  Service provider name(s) \_\_\_\_\_

Parent Name(s) \_\_\_\_\_ (Other Parent) \_\_\_\_\_

Address \_\_\_\_\_ (Other Parent) \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_ (if different address) Street \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Other Parent) (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_  
(if different home phone)

Parent E-mail \_\_\_\_\_ (Other Parent) E-mail \_\_\_\_\_

**Please indicate which services you are requesting:** (It is the responsibility of school districts/agencies to obtain parental permission and release of information for all Outreach Services requested. Please also include child's most recent ocular report.)

	O&M (Required for Initial or Re-eval)  <input type="checkbox"/> District has O&M staff	Multiple Disabilities	Low Vision, Braille/LP, Reading or Learning Media	Birth-3/ Early Childhood  (For ages B-6)	Assistive Technology	Transition  (For ages 14-21)	Deaf- Blind	Check if for:  <input type="checkbox"/> IFSP <input type="checkbox"/> IEP <input type="checkbox"/> 90-Day Eval
Initial Evaluation for IEP/ IFSP								Due Date:
3-Year IEP/IFSP Re-evaluation								Due Date:
Consultation (Please specify goals or needs)								

**Student's Reading Media** (please check ALL that apply):  Pre-literate  Non-reader  Undetermined  Braille  Auditory  
 Regular Print (with Magnification)  Regular Print (without Magnification)  Enlarged Print (print size: \_\_\_\_\_)

**Suspected or Identified EEN (check all that apply):**

- Visual Disability
- Emotional Disturbance
- Autism
- Physical/Orthopedic Disability
- Learning Disability
- Significant Developmental Delay
- Cognitive Disability
- Deaf/Hard of Hearing
- Other Health Impaired \_\_\_\_\_
- Speech/Language Disability
- Traumatic Brain Injury

**Send referral and all appropriate pupil data to:**  
Stacy Grandt, Director of Outreach Services, WCBVI  
1700 W State Street, Janesville WI 53546  
Toll Free: 866-284-1107, Direct 608-758-6145  
stacy.grandt@wcbvi.k12.wi.us

WCBVI Staff Use:	
Copies to:	
<input type="checkbox"/> MT OM	<input type="checkbox"/> SG MD
<input type="checkbox"/> LL VI	<input type="checkbox"/> TW B-6
<input type="checkbox"/> CH AT	<input type="checkbox"/> DB Trans
<input type="checkbox"/> HH D-B	
Received _____	