



COOPERATIVE ASSOCIATION for SPECIAL EDUCATION

Itinerant Services Office

1104 N Main Street
Lombard IL 60148-1362

Voice or TTY (630) 629-2600
FAX (630) 629-2601

Jim Nelson
Executive Director

REQUEST FOR ORIENTATION & MOBILITY SERVICES

Functional Hearing Assessment: _____

Functional Vision Assessment: _____

Orientation & Mobility Assessment: _____

PROCEDURES:

Check service(s) desired. Teacher obtains coordinator's approval. Coordinator checks with district and Routes to CASE Itinerants Services offices. **This form should be utilized only for students receiving CASE Itinerants Services. Please attach copy of last IEP.**

Name of Pupil: _____ Date of Birth: _____

Parents: _____ Address: _____

City: _____ Zip: _____

Phone: _____ Date of Request: _____

District of Residence: _____

School: _____ Class: _____

School Phone: _____ School Phone: _____

School Nurse _____ Town: _____

Specific reason for request and description of problem: _____

Have there been any pre-referral interventions attempted? YES _____ NO _____ If yes, please attach.

Teacher's Signature: _____

Name of District Representative: _____ **Contracted:** _____

Coordinator's Signature: _____

(Signature indicates district has been notified and approved this request.)