



This document may be completed electronically or printed and sent via USPS, Fax (804.828.0042), or scanned and sent as email attachment to awHughes@vcu.edu.

# VNOCC Service Request Form

Virginia Network of Consultants  
For Professionals Working with Children Who are Deaf or Hard of Hearing

## Part 1: Student/Program Information

School: \_\_\_\_\_

School Division: \_\_\_\_\_

Person Requesting VNOCC Service: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Request applies to:  One Student (Complete Part 2 and Part 3)  School Program (Go to Part 3)

## Part 2: Please complete if VNOCC service requested relates to one student

Student Name: \_\_\_\_\_ DOB/Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Disability Category\*: \_\_\_\_\_ Program/Placement: \_\_\_\_\_

(\*If Multi-disability please describe) \_\_\_\_\_

Length of time in current placement: \_\_\_\_\_

Student's Primary Communication Modality: Receptive - \_\_\_\_\_ Expressive - \_\_\_\_\_

Assistive technology devices used (Check all that apply and describe frequency of use; e.g., consistent, school only, occasional, etc.):

Hearing aids \_\_\_\_\_

Cochlear implant \_\_\_\_\_

FM System \_\_\_\_\_

Other \_\_\_\_\_

## Additional team members, their positions and frequency of service:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

*(A team may consist of classroom teachers, instructional assistants, interpreters, speech/language pathologists, occupational therapists, physical therapists, and/or any other school/agency personnel who work with the child/program in question.)*

**Reason for VNOG Service Request:**

**Context in which problem/concern occurs (if applicable):**

**Previously Implemented Classroom/Instructional Strategies:**

*Attach additional information as needed.*

Strategies:	Outcomes:
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**School or Division-Level Personnel or Resources Previously Consulted:**

*Copy and attach additional pages as needed.*

<b>1. Name/Position/Contact Info:</b>	
Recommendations:	Outcomes:

<b>2. Name/Position/Contact Info:</b>	
Recommendations:	Outcomes:

**Part 3: Specific Service Request/Team's Desired Outcome:**

**Parental Notice and Consent Verification:** The local school division/agency has obtained the necessary parental consent, including consent for testing if applicable, and release of information for this VNOC Service Request. Consent form is filed according to school division/agency procedures. *Consent must be documented on the appropriate school division/agency form prior to the provision of VNOC services.*

\_\_\_\_\_  
Initials: Person Requesting VNOC Service

***By signing and returning this form, I verify that I have consulted with the appropriate personnel and/or resources within the school and school division or agency in order to address this specific problem/concern. If this request applies to one specific student, I agree to work with a team of educators in the school/agency on the professional development necessary to assist the IEP team in meeting the needs of the student.***

\_\_\_\_\_  
Person Requesting Service (PRINT)

\_\_\_\_\_  
Title

\_\_\_\_\_  
\*Signature

\_\_\_\_\_  
Date

\*Person requesting service may insert initials on Signature line to serve as electronic signature or may print this form, provide full signature and send to Authorizing Administrator before submitting to VNOC.

**Authorized by:**

\_\_\_\_\_  
Authorizing Administrator (PRINT)

\_\_\_\_\_  
Title

\_\_\_\_\_  
\*Authorizing Administrator's Signature

\_\_\_\_\_  
Date

\*Authorizing Administrator may insert initials on Signature line to serve as electronic signature or may print this form, provide full signature and return via fax (804-828-0042) or scan and send via email attachment to Ann Hughes, VNOC Coordinator [awhughes@vcu.edu](mailto:awhughes@vcu.edu).

E-mail: \_\_\_\_\_ Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

**Portion below to be completed by VNOC Coordinator**

Date received by VNOC Coordinator: \_\_\_\_\_

Person/contact information identified by the authorizing administrator as the primary contact person for the VNOC consultant assigned to this service request.

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_