PHYSICIAN REFERRAL FORM

SECTION 1 – TO BE COMPLETED BY THE STUDENT'S PHYSICIAN(S)

Student Name	Date of Birth	
Physician/Psychiatrist Name	Office Telephone Number	Office Fax Number
Physician/Psychiatrist Office Address	Physician/Psychiatrist Area of Specialty	

INCOMPLETE FORMS WILL BE RETURNED.

NOTE TO THE PHSYCIAN/PSYCHIATRIST. PLEASE READ CAREFULLY:
The student listed above is being considered for Hospital Homebound Services which are ***temporary*** and occur in the hospital or student's home. Hospital Homebound instruction can never replace classroom learning. Your medical recommendations are needed to assist us in determining eligibility. A student is medically eligible for Hospital Homebound Services if the absence is anticipated to be at least 15 days.

EXPECTED DATE OF RETURN:
The physician/psychiatrist must report an anticipated date the student can return to attending his/her home school. The date cannot be longer than one year. If an undetermined date is indicated, the form will be ***returned*** to the physician/psychiatrist for an expected date of return. Returned forms will delay the student's possible placement for Hospital Homebound Services. If during treatment, the physician/psychiatrist needs to extend the expected date of return to school, the physician/psychiatrist may do so by providing a completed Physician Referral Form to the Hospital Homebound office.

Start Date for Services _____

Expected School Return Date _____

SECTION 2 – TO BE COMPLETED BY STUDENT'S PHYSICIAN(S)

PHYSICIAN'S TREATMENT PLAN

Please complete the following:

1. Please indicate the student's diagnosis:

2. Explain in detail how the physical or psychiatric condition you have diagnosed will significantly limit the student's ability to receive educational benefit in the regular school setting. In what way(s) would the student's ability to function in the school setting be jeopardized?

3. List any medication(s) the child is taking and explain the effects, if any, the medication(s) may have on the student's ability to participate in the school setting and/or Hospital Homebound Services.

4. Please describe the treatment plan (include the frequency and duration of the treatment) you have developed to assist the student to return to school. Please include components of your plan which specifically address medication, limitations, and the return of the student to the school setting.

SECTION 3 – TO BE COMPLETED BY STUDENT'S PHYSICIAN(S)

All questions must be answered to determine eligibility for services.

Yes No Initial

1. Is the student under medical care for illness or injury which is acute, catastrophic, or chronic in nature?
2. Is the student expected to be absent from school due to a physical or psychiatric condition for at least 15 school days?
3. Will the student be well enough to participate in and benefit from an instructional program?
4. Is the student confined to his/her home or to a hospital due to his/her medical condition?
5. Can the student receive instructional services without endangering the health and safety of the instructor or other students the instructor may come in contact with?
6. Is the student a danger to themselves?
7. Is the student a danger to others, including the teacher who will be providing services in the home or hospital.

RECOMMENDED SERVICE MODEL (please select one):

_____ Full-time Hospital Homebound Services – Student is UNABLE to attend ANY portion of the school day.
_____ Part-time Hospital Homebound Services – Student is ABLE to attend a partial school day/week.
_____ Attend school part of the day for _____ hours.
_____ Attend school on non-consecutive days based on chronic condition.

Hospital Homebound services are provided in a variety of formats. Please answer if the student is medically able to participate in the following educational delivery formats:

1. Teleclass – teacher and student are on the phone for the prescribed class
   Yes No If no, please describe how the medical condition prohibits participation in teleclass:

2. Virtual Class – teacher presents information via the computer.
   Yes No If no, please describe how the medical condition prohibits participation in Virtual class:

PHYSICIAN'S CERTIFICATION: I certify that this student is under my care and treatment for the reasons listed above. My recommendation has been made on the medical needs of the student, keeping in mind that the student will be removed from the school setting.

This certifies that this treatment plan is medically necessary. Date: _____

_____ _____
Print Physician's Name Physician's Signature

If ARNP or PA signs above, the name/phone number of the supervising physician is required below.

_____ _____
Supervising Physician Name Supervising Physician Phone