GENERAL EDUCATION

Homebound-Hospital Education Center
475 Corporate Square Drive, Winston-Salem, North Carolina 27101
Phone: (336) 727-2083 Fax (336) 661-3079 LEA 340394

OB/GYN Physician's Referral For Homebound Services

(Please type or print- all areas need to be completed before faxing to the homebound office)

Student's Last Name _____ Student's First Name _____

Student Number _____ Date of Birth _____

School of Record _____ Grade _____

I authorize my child's doctor, _____ to complete this medical referral and to release appropriate medical information needed to request homebound/ hospital instructional services for me. In addition, the homebound staff may release appropriate homebound services/ instructional information to my child's doctor.

Parent Signature _____ **Date** _____

NOTE TO PHYSICIAN: Please Read Carefully

The student named above is being considered for homebound instruction. The homebound program provides **temporary** instructional services in private homes for students who are referred from appropriate school system sources. Homebound instruction can never replace classroom learning. Your medical recommendations are needed.

Unless there is a documented complication that would cause a danger to the unborn child or the mother, homebound services will begin the date of delivery or the due date (whichever comes first). If you feel the student needs to leave school earlier than the timeframe listed above, the student can be marked absent-excused, but would be responsible for picking up assignments until her delivery date or due date (whichever comes first).

If complications during pregnancy require a need for homebound services, please be specific as to the nature of the complication and the amount of time you expect this student to need to remain out of school.

Extending homebound services beyond six weeks requires a physician's reassessment of the student's medical condition with written recommendations sent to the Homebound/ Hospital Education Center Director.

Diagnosis _____

Anticipated due date _____

Anticipated date of return to school after delivery _____

Date of Office Visit _____

Complication with pregnancy, if any _____

Does this complication require homebound services? ____ YES ____ NO

Anticipated date of return to school following treatment of complication _____

Physician's Name _____ Physician's Signature _____ Date _____

Office Phone Number _____ Office Fax Number _____