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

Psychiatric/ Mental Health Referral for Homebound Services

(Please type or print- all areas need to be completed before faxing to Homebound Office)

Student's Legal Name _____ (Last) _____ (First) _____ (MI) Student Number _____

Grade _____ Date of Birth _____ School of Record _____

Name of Parent/ Guardian(s) _____

I authorize my child's psychiatrist, _____, to complete this referral and to release Appropriate medical information needed to request homebound-hospital instructional services for my son/ daughter. In addition, the homebound staff may release appropriate homebound services/ instructional information to my child's doctor.
**** Parent and/ or Guardian, please note the anticipated return to school date for your student.**

Parent/ Guardian Signature _____ Date _____

NOTE TO PSYCHIATRIST: **Please read the first page of this referral 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 mental health recommendations are needed. **(All blanks need to be completed before faxing to our office.)**

A student is eligible for homebound services if the absence at home is anticipated to be at least four weeks.
Please review procedures on page one of this referral.
Parents are responsible for providing updated psychiatric referrals to the school as well as Homebound office.

A **transition plan** needs to be discussed with the student and parent before the end of the homebound placement. Extending homebound services beyond six weeks requires a physician's reassessment of the student/ child's medical condition with a written **recommendation/ treatment plan (section 2/3)** sent to the Homebound-Hospital Center Manager. Fax: 336-661-3079.

Medical diagnosis _____

Pertinent medical information which would have an impact on educational needs:

Does this condition prohibit school attendance by this student? ___ YES ___ NO

***Do you recommend homebound instruction? ___ YES ___ NO

Anticipated date of return to school: _____ (must be a 3-part date)
Date of Office Visit _____

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

Office Phone Number _____ Office Fax Number _____

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

PHYSICIAN'S TREATMENT PLAN

Please complete the following:

Please indicate the student's diagnosis below:

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?

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 Homebound- Hospital Services.

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.

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

All questions must be answered to determine eligibility for Homebound-Hospital Services

	YES		NO	Is the student under medical care for illness or injury which is acute, catastrophic or chronic in nature?
	YES		NO	Is the student expected to be absent from school due to a physical or psychiatric condition for at least 15 school days?
	YES		NO	Will the student be well enough to participate in and benefit from an instructional program?
	YES		NO	Is the student confined to his/her home or to a hospital due to his/her medical condition?
	YES		NO	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?
	YES		NO	Is the student a danger to themselves?
	YES		NO	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 Homebound-Hospital Services- student is **UNABLE** to attend **ANY** portion of the school day.

___ Part-time Homebound-Hospital 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.

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

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:

Virtual Class- teacher presents information via the computer.				
	YES		NO	If no, please describe how the medical condition prohibits participation in teleclass:

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

_____ _____

Supervising Physician Name Supervising Physician Phone Number

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