



EXCEPTIONAL CHILDREN

**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 \_\_\_\_\_