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Hospital/Homebound (HHB) Application

**2018-19 Medical Physician/PA/APRN Referral & Certification Form**

Hall County Schools

711 Green Street Gainesville, GA 30501 (770) 534.1080 Fax: (770) 533.4015

Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| ***ONLY A PHYSICIAN (\*\* PA/APRN) licensed by the State of Georgia may complete this form. Incomplete information may delay services.*** |

Physician’s/Psychiatrist’s Name **(Please Print)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GA License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Agreement/Release for Medical Information**:

I have read the Hospital/Homebound policies for program eligibility and I understand the reasons for possible dismissal from the program. I agree to the policies and requirements of the program and request Hospital/Homebound services for my child. I hereby give permission for the attending licensed physician or licensed psychiatrist for the diagnosis presented to communicate information regarding my child’s medical/emotional condition for which he/she is referred.

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**Parent/Guardian Signature** Date

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| **Part A. Physician/PA/APRN Statement and Diagnosis** |

Please complete the following information keeping in mind that Hospital Homebound Services is the **most restrictive environment** for a student and that many accommodations can be made for the student at school. This information will be used to determine eligibility for HHB services and must be completed by the licensed psychiatrist who is currently treating the student for the presenting diagnosis

Patient’s **DIAGNOSIS and Prognosis** (Include a description of the condition preventing the student from attending school) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**START DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ END DATE (\*\*Required.** Please do not omit): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Must include a start and end date. Not to exceed 8 weeks. For extensions, verification with an updated treatment plan is required.

*\*\*\*Due to scheduling purposes, PLEASE DO NOT list “unknown or undetermined. “If undetermined” put date of NEXT appointment or when will be determined.*

**If pregnant EDC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please answer the following questions.**

* Is the student ***unable to attend school for a minimum of 10 consecutive school days***? Yes\_\_\_\_ No\_\_\_\_
* Is the student able to ***benefit from an instructional program during this time of confinement***? Yes\_\_\_\_ No\_\_\_\_
* Is the student confined to the home or hospital? Yes\_\_\_\_ No\_\_\_\_
* **Could the student attend school regularly** and receive Hospital/Homebound services on an ***INTERMITTENT basis***, as needed? *(Intermittent is designed for students with chronic or long term illness (e.g. CA) who will be absent for treatment or appointments 3 or more days at a time for greater than 10 total during the school year).*  Yes\_\_\_\_ No\_\_\_\_
* Is the student free from communicable disease? Yes\_\_\_\_ No\_\_\_\_
* Can instruction be provided to the student without endangering the health of the

instructor or other students whom the instructor may contact?

Yes\_\_\_\_ No\_\_\_\_

Hospital/Homebound Referral & Certification Form (Page 2)

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any accommodations that can be provided that would enable the student to attend school? (i.e. shortened day, wheelchair accessibility, etc.) \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Part B. Treatment and School Re-entry Plan** |

*The following information is required to determine eligibility for Hospital/Homebound services and must be completed by the licensed physician or licensed psychiatrist who is currently treating the student for the diagnosis presented*.

* What is the treatment/therapy schedule for this student? Daily\_\_\_\_ Weekly\_\_\_\_ Monthly\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other
* What is the expected duration of the treatment/therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Will the student take medication? Yes\_\_\_\_ No\_\_

1. Please complete the following information for each medication that the student will take

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| --- | --- | --- | --- |
| *Name of Medication* | *Effects on student’s ability to comprehend* | *Effects on student’s ability to complete independent assignments* | *Effects on student’s ability to relate to teachers and other students.* |
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**Re-entry Plan**

The Hospital/Homebound program is designed to be a *temporary educational program* to help children who are unable to attend school for medical reasons. Please describe your ***time frame and transitional plan for the student’s re-entry to school***: (Attach additional sheets as needed). Please list any limitations the student will have or special accommodations the student will require upon his/her return to school. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**\*Physician Certification:** *I* ***CERTIFY*** *that this student is under my care and treatment for the aforementioned medical condition.* My recommendation has been based on the medical needs of the patient, keeping in mind that school attendance is important for a student to complete his/her education and attending school is preferable to HHB instruction when possible.

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LICENSED Physician ***Printed*** Name Date

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LICENSED Physician Signature Date

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Advanced Practice Provider Signature (on behalf of Licensed Physician written above) Date

Stamp: Revised 8/17