

 Page 1

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

**Hospital Homebound**

**2019-20 Psychiatrist Referral Request Form**

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

|  |
| --- |
| ***ONLY A PSYCHIATRIST/PA/APRN licensed by the State of Georgia may complete this form. Incomplete information may delay services.***  |

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

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 psychiatrist for the diagnosis presented to communicate information regarding my child’s medical/emotional condition for which he/she is referred.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Signature** Date

|  |
| --- |
| **Part A. Psychiatrist/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 (i.e. modified schedule, half days, frequent breaks/rest periods, etc.) 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**  (Include a description of the condition preventing the student from attending school): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**START DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ END DATE (\*Required/**Please do not omit): **\_\_\_\_\_\_\_\_\_\_\_\_\_ (not to exceed 8 weeks**)

*Must include a start and end date. An updated treatment plan in writing is REQUIRED before extensions past 8 weeks will be approved.*

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

**Psychiatrist/PA/APRN Statement: Please answer the following questions.**

* Is the student ***unable to attend school for a minimum of 10 consecutive school days***? Yes\_\_\_ No\_\_\_
* Could the student ***attend school with accommodations***? If so, describe: Yes\_\_\_ No\_\_\_
* Will the student be able to participate in, and benefit from, an instructional program during this time of confinement? Yes\_\_\_ No\_\_\_
* Could the student attend school for a partial day or half days as tolerated? Yes\_\_\_ No \_\_
* Is the student confined to the home or hospital? Yes\_\_\_ No\_\_\_



Hospital/Homebound Referral & Certification Form (Page 2)

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

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

**TREATMENT PLAN:**

1. How long has the patient been under your care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How often is the patient seen by you for evaluation/treatment? \_\_\_\_ Weekly \_\_\_\_ Monthly \_\_\_\_\_\_\_\_other

3. Is the patient currently seeing a licensed counselor or therapist? \_\_\_\_\_ Yes \_\_\_\_\_ No

 If yes, who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. If yes, how often is the student receiving counseling/therapy? \_\_\_\_ Weekly \_\_\_\_ Bi Weekly \_\_\_\_ Monthly

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other

5. What is the expected duration of the treatment plan? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Is the patient taking medication? \_\_\_\_Yes \_\_\_\_ No

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *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.* |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**RE-ENTRY PLAN:**

The HHB program is designed to be a *temporary education program*. A gradual re-entry plan will be implemented. Please give recommendations to take into consideration for the re-entry plan. Some re-entry options may include:

(1) Homebound teacher meets with the student at school. (2) Student will attend school for one class. (3) Student will increase time at school by one class every 2 to 3 weeks. (4) Implement safety/support plan for student.

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

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

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

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

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

**PSYCHIATRIST’S or ADVANCED PRACTICE PROVIDER’S CERTIFICATION:**

I certify that this patient is under my care and treatment for the aforementioned medical condition. My recommendations are based on the medical needs of this patient, keeping in mind that attendance in school is important for a student to complete his/her education and that attendance in school is preferable to HHB instruction.

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

LICENSED Psychiatrist’s ***Printed*** Name Date

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

LICENSED Psychiatrist’s Signature Date

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

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

Stamp: Revised 8/19