APPLING COUNTY SCHOOL SYSTEM
HOSPITAL HOMEBOUND SERVICES
Medical Referral – Form B

Licensed Physician/Psychiatrist Statement and Medical Referral Form

(Note: This form must be completed by a physician or psychiatrist licensed by the State of Georgia.)

Physician/Psychiatrist Name: _____

GA License #: _____

Address: _____

_____

City: State: ZIP:

Phone # _____ Fax: _____

Student Information

Student Name: _____

Last First MI

Address: _____

_____

City: State: ZIP:

M ☐ F ☐ Date of Birth: _____

Parent/Guardian: _____

Last First MI

Phone: (H) _____ (W) _____ (C)_____

Physician/Psychiatrist Statement and Diagnosis

Patient's Diagnosis: (*Note: Please include a description of the condition.*)

_____

_____

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_____

Estimated Duration of HHB Services:

Starting Date: _____
Ending Date: _____
Date of Initial Evaluation: _____
Date of Next Scheduled Appointment: _____

Physician's Statement: (*Note: Please answer the following questions keeping in mind that the least restrictive environment is preferred.)*

- Is the student unable to attend school for a minimum of ten consecutive school days?
  YES ☐ NO ☐
- Will the student be able to benefit from an instructional program during this time of confinement?
  YES ☐ NO ☐
- Could the student attend school with accommodations? If so, describe.
  YES ☐ NO ☐

Recommendations for Accommodations:

_____
_____
_____
_____
_____
_____
_____
_____
_____

- Could the student attend school regularly and receive HHB services on an intermittent basis as needed?
  YES ☐ NO ☐

- Is the student confined to the home or hospital and full-time HHB services are recommended?
  YES ☐ NO ☐

- Is the student free from communicable diseases, such as flu or contagious airborne diseases?
  YES ☐ NO ☐

- Can instruction be provided to the student without endangering the health of the teacher or other students whom the teacher may contact?
  YES ☐ NO ☐

(Note: You may periodically have to verify that the student remains under your care and continues to qualify for the HHB services program.)

Treatment and School Recovery Reentry Plan

(Note: The following information is required to determine eligibility for HHB 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 scheduled frequency of treatment/therapy for this student?
  - ☐ Daily
  - ☐ Weekly
  - ☐ Monthly

- What is the expected duration of the treatment/therapy? _____

- Will the student take medication?
  YES ☐ NO ☐

Medications student will take for diagnosis:

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

- Could this student return to school on an intermittent basis after his or her medication and condition is stabilized?
  YES ☐ NO ☐

- Can this student come into contact with other students?
  YES ☐ NO ☐

The HHB services program is designed to be a temporary educational program to help students who are unable to attend school for medical or psychiatric reasons. Please describe your time frame and transitional plan for the student's reentry to school (attach additional pages as needed).

Physician's 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 the least restrictive environment is preferred.

Physician Printed Name Date

Physician Signature Date