VISTA UNIFIED SCHOOL DISTRICT

Home/Hospital Instruction
TREATMENT PLAN

PATIENT INFORMATION

Student Name ____

Parent/Guardian Name(s) ____

Address ____
Street Address City

Phones: ____________________ ____________________ ____________________
Home Work Cell

Home Teacher is recommended for approximately _________ (# of weeks)

DSM IV-R Diagnosis:
Specific Symptoms/Problems:
Treatment Strategies:
Expected Outcome/Placement:
Medication Regimen:

Physician/Therapist Signature and Title ______________________________________

Phone: _______________________________ Date ________________________