PASADENA UNIFIED SCHOOL DISTRICT
EDUCATION CENTER • HEALTH PROGRAMS

Our Children. Learning Today. Leading Tomorrow.

MENTAL HEALTH REFERRAL FOR HOME HOSPITAL INSTRUCTION

School: Please complete the Student Information: **Aeries Student ID#:**_____

Name:	M ☐ F ☐	DOB / /	Grade:	School:
Address:		City:		Zip:
Home Phone: ( )	Cell Phone: ( )		Work Phone: ( )	
Parent/Guardian:				IEP Yes ☐ No☐
Date of Current IEP:	Eligibility:	Next Review Date:		

This section to be completed by Parent/ Legal Guardian

PARENT/GUARDIAN AUTHORIZATION TO RECEIVE/RELEASE MEDICAL & ACADEMIC INFORMATION to Pasadena Unified School District:

Parent Signature: _____ Date:_____

This section to be completed by student's attending Psychiatrist/ Doctor

DSM IV Diagnosis and/or Temporary Disability making school attendance impossible or inadvisable: _____

_____

Summary of the therapeutic plan, including medications and aspects involving returning to school campus attendance:

_____

_____

_____

Is student now hospitalized? Yes ☐ No ☐ If yes, where? _____

Anticipated Discharge Date:_____

Based on current mental health status, is student mentally/emotionally capable of attending school at this time? Yes ☐ No ☐

If no to above question, is the student presently receiving psychiatric support for stabilization? Yes ☐ No ☐

Is student dangerous for self/others and poses an immediate threat? Yes ☐ No ☐

➡ **Effective Date** _____ **AND Estimated date of student resuming attendance on the school campus** _____

Attending Clinician Signature: _____ Date:_____

Supervising Clinician/Psychiatrist Signature:_____ Date:_____

Provider/Agency Name: _____ Phone: (___)_____

Address:_____ Fax: (___)_____

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