

PINELLAS COUNTY SCHOOLS
EXCEPTIONAL STUDENT EDUCATION (ESE)
HOSPITAL/HOMEBOUND SERVICES PHYSICIAN/PSYCHIATRIST REFERRAL

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*** Please note detailed instructions at end of packet*

Student Name: _____ Age: _____ Date of Birth: _____

PARENTAL/ADULT STUDENT PERMISSION: (Signed by the Parent/Guardian or Student who is 18 years or older)

I hereby authorize the physician/psychiatrist to release all information concerning diagnosis, treatment, and any medical implications for instruction to the Pinellas County School District. This communication may be written or verbal. This release will remain in effect until the student has been dismissed from Hospital/Homebound Services.

Parent/Guardian/Adult Student Signature

Date

To be completed by Physician/Psychiatrist (REQUIRED)*

*Incomplete forms will be returned

ELIGIBILITY: The licensed physician/psychiatrist must certify that the student meets ALL the following criteria for eligibility. Students who do not meet all minimum eligibility criteria listed below will not be eligible for Hospital/Homebound Services.

All questions must be answered "Yes" and initialed by the physician to certify eligibility.

☐ Yes ☐ No Is the student expected to be absent from school for at least fifteen (15) consecutive school days or seven consecutive school days (4 x 4 schedule) as the result of an acute, catastrophic, or chronic medical or psychiatric condition? **Initial** ____

☐ Yes ☐ No Is the student confined to home or hospital? **Initial** ____

☐ Yes ☐ No Will the student be able to participate and benefit from an instructional program? **Initial** ____

☐ Yes ☐ No Is the student under medical care for illness or injury which is acute, catastrophic or chronic in nature? **Initial** ____

☐ Yes ☐ No Can the student receive instructional services without endangering the health and safety of the Instructor or other students with whom the instructor may have contact with? **Initial** ____

Current Medical/Psychiatric Diagnosis*: _____

*If psychiatric diagnosis, please answer the following questions:

1) What is the current treatment plan? _____

2) Is the student currently engaging with the treatment plan? ☐ Yes ☐ No

3) How does the treatment plan support a return to school? _____

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Student Name: _____ Age: _____ Date of Birth: _____
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Student last seen by Physician/Psychiatrist on: _____

Treatment Plan and Other Information (check all that apply):

☐ Medication Mgmt.	☐ Chemotherapy	☐ Bed Rest	☐ Surgical Mgmt.
☐ Dialysis	☐ Post-surgical recovery	☐ Hospitalization	☐ Psychotherapy
Frequent medical monitoring and follow-up: Frequency _____			
Other: _____			

Treatment/Counseling Schedule:

☐ Daily	☐ Weekly	☐ Bi-weekly	☐ Monthly	☐ Other: _____
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Expected Duration of Treatment from: _____ to _____
Date Date

Current Medications (list any medications the student is taking **and** explain the effects, if any, the medications may have on the child's ability to achieve educational benefit in the school setting): _____

The Hospital/Homebound Program is designed to be a temporary educational program to help students who are unable to attend school for medical or psychiatric reasons. The amount of live instruction provided by the Hospital/Homebound Programs is significantly less than provided in the regular school setting. Students entering the Full-time Hospital/Homebound Instructional program will be placed in the most restrictive educational and social environment in which the student will not have physical contact with peers during the school day. Students who are confined to the home or hospital receive specially designed instruction as indicated in their Individual Education Plan in a one-on-one setting. Students complete content curriculum in the home supported by the parent with access to teachers via phone/email/Teams appointments.

Do you recommend the student be placed in this most restrictive environment? ☐ Yes ☐ No Initial _____

Medical implications for instruction (restrictions, precautions, etc.): _____

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Student Name: _____ Age: _____ Date of Birth: _____
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Estimated length of time student will be unable to attend school**: Weeks _____ Months _____
(**maximum of 12 months)

Recommended Placement: ☐ Full-Time Homebound or ☐ Intermittent Hospital/Homebound (please describe):

Implementation Date: _____

Anticipated Re-entry Date: _____

This certifies that the student named in this referral has a medical or psychiatric condition that confines him/her to the home or hospital and will be able to benefit from the Homebound instructional program.

(Physician/Psychiatrist Signature) _____ (Date)

(Physician/Psychiatrist Printed Name)

Physician/Psychiatrist Address:

Physician/Psychiatrist Office Phone number:

NOTE: If an ARNP or PA signs, the name & phone # of supervising physician is required below

Supervising Physician (Please Print) Phone Number Date

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****Instructions**

The determination of eligibility for Hospital/Homebound services is done in accordance with State Board of Education Rule 6A-6.03020. The following instructions are provided to assist in completing the Physician/Psychiatrist Referral form so that all eligibility criteria are addressed. Please note that this referral will not mandate Hospital/Homebound services, but it provides evaluation data to be used by the Individual Education Plan (IEP) committee to determine eligibility.

ELIGIBILITY: All questions must be ✓'d "Yes" and initialed by the physician to certify that the student has met the outlined criteria.

Important: Pregnancy is not considered a medical condition that meets eligibility criteria for Homebound unless a physician certifies that the medical condition confines the student to the home or hospital and restricts activities for at least 15 consecutive school days. Medical information for a pregnant student needs to include: 1) the specific medical condition, 2) the estimated date of delivery, and 3) the estimated length of time the student will be confined.

Current Medical/Psychiatric Diagnosis: please be specific and descriptive.

Student last seen by physician on: Please include a recent date*

*The student must be under the medical care of a physician for an illness or injury which is acute, catastrophic, or chronic in nature

Treatment Plan and Other Information: Please ✓ all treatment modalities/methods that are applicable.

– If you ✓ "Frequent medical monitoring and follow up", specify frequency.

– If you ✓ "other", please describe.

Treatment/Counseling Schedule: please ✓ frequency.

Expected Duration of Treatment: please provide specific dates.

Current Medications: list medications; be sure to include how the medications might impact the student's ability to access and benefit from their education while taking these medications.

Do you recommend the student be placed in this most restrictive environment? Please read paragraph above this question and then ✓ "Yes" or "No" and initial your response.

Medical implications for instruction (restrictions, precautions, etc.): please be specific about any precautions related to positioning, movement, or risks related to medical condition that service providers need to be aware of when working with student.

Estimated length of time student will be unable to attend school: please specify in weeks or months (12 months maximum).

Recommended Placement: Full-time or Intermittent (The student accesses H/H services intermittently due to a chronic illness for which the treatment or recovery period lasts 15 or more consecutive school days).

Implementation Date: date for homebound instruction to begin.

Anticipated Re-entry Date: this is a requirement for eligibility.

Physician Signature: Be sure to sign/date AND print name; if an ARNP or PA signs the referral, the name of the supervising physician must be printed underneath.