Homebound Instruction Referral

Return Completed form to: Health Services, 1415 N. 26th St., St. Joseph, MO 64506
Email: tamarasmith-hinchey@sjsd.k12.mo.us Fax: 816-671-4013

Section 1: To be completed by Principal/Designee or Building Process Consultant

Date____________ Referred By:________________________________School:________________

Student Name: ___________________________ DOB:____________________ Grade:__________

Parent or Guardian: ____

Home Address: ____ Zip Code:___________________

Home Phone:________________________ Work:_______________________ Cell:______________

Please "X" the appropriate classification and type:
Classification: _____IEP** _____Nondisabled _____504
Type of Referral:_____Medical* _____Med Extension* _____Suspension _____Other

*Date of IEP or 504 Meeting in which placement was changed to Homebound:____________

A medical referral requires completion of the section below and DESE HB form faxed to physician.
Physician: ____ Phone:______________________
Address: ____ Fax:_________________________
Initial Diagnosis:____

____
Signature: Principal/Designee or Process Consultant Date

Section II: To be completed by Homebound Program Facilitator

HB Instructor Recommendation
Instructor Name:____ Phone:_________________
HB Initial Start Date:___/____/____ HB Initial End Date:___/____/____Intermittent? Yes No

Request for Extension of HB
EXT REQUESTED: ___/____/____ NO. WEEKS ( ) EXT START:___/____/____ EXT END:___/____/____

DOCUMENT TRACKING
___ ___ ___HB Referral Rec'd from Building
___ ___ ___Physician Medical Application Rec'd
___ ___ ___Director Approval/Denial Sent to Bldg

HOMEBOUND FACILITATOR USE ONLY
HB referral Approved ____ Yes ____ No_____
Date______________