

Licensed Physician/Psychiatrist Statement & Medical Referral Form (2026-2027)

(Note: This form must be completed by a State of Georgia licensed physician or psychiatrist who is currently treating the student to determine the student's eligibility for HHB Services.)

Please complete all 3 pages – ALL FIELDS MUST BE COMPLETED FOR CONSIDERATION

STUDENT INFORMATION:

Student Name: _____ School Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Parent/Guardian: _____

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

TREATING PHYSICIAN'S INFORMATION:

Treating Physician/Psychiatrist Name: _____ GA License #: _____

Name of Physicians Practicing Office/Hospital: _____

Address: _____ City: _____ GA Zip Code: _____

Phone Number: _____ Fax: _____ E-Mail: _____

PHYSICIAN/PSYCHIATRIST STATEMENT AND DIAGNOSIS:

PATIENT'S DIAGNOSIS: _____

(a medical diagnosis must be included)

Is the student pregnant? Yes ☐ No ☐ Due date: _____

**Pregnant students will not be approved for HHB services until after delivery, unless there are medical complications that require bedrest.*

Does the student have a CHRONIC health condition that requires ongoing care/treatment during the school day?

Yes ☐ No ☐

ESTIMATED DURATION OF HHB SERVICES: *(Psychiatric referrals must be renewed every 60 days)*

HHB Start Date: _____ **HHB End Date** *(cannot go beyond 5/26/2027)* _____

Date of Examination: _____ **Date of Next Scheduled Appointment:** _____

RECOMMENDED HHB SERVICE TYPE:

☐ **FULL-TIME** - student is completely confined to the home due to the documented diagnosis above

☐ **INTERMITTENT** - student should attend school (in-person) as much as possible but may have periodic absences (3 consecutive days or more) due to the documented diagnosis above

INTERMITTENT HHB SERVICES

Please complete this section its entirety **ONLY IF INTERMITTENT HHB** services are recommended. Please consider Intermittent HHB if the student has a chronic condition that may require treatment at a minimum of ten school days per year. Intermittent students with extended absences may be referred back to treating physician for full-time HHB consideration.

- **Could the student attend school intermittently (in-person) while receiving treatment?** Yes ☐ No ☐
If no, please proceed to next section. If yes, list the recommended accommodations while the student attends school.

Recommendations for Accommodations:

- Can this student come into contact with other students? Yes ☐ No ☐
- Will the student undergo medical treatment under your care during their HHB service period?
Yes ☐ No ☐ How often will they receive care? Weekly ☐ Biweekly ☐ Other: _____

FULL-TIME HHB SERVICES

Please complete this section in its entirety **ONLY IF FULL-TIME HHB** services are recommended. Please note that Full-Time HHB **does not** include virtual/online classes and **is not** equivalent to virtual learning. HHB student will receive work to complete while at home and will meet with a HHB teacher virtually up to 3 hours a week, unless otherwise stated per student's Individualized Education Plan.

- Is the student unable to attend school for a minimum of 10 consecutive school days (after today's date)?
Yes ☐ No ☐
- Will the student be able to participate/benefit from a virtual instructional program during this time of confinement? Yes ☐ No ☐
- Is the student confined to the home or hospital? HOME ☐ HOSPITAL ☐ NEITHER ☐
- Is the student free from communicable diseases, such as flu or contagious airborne disease?
Yes ☐ No ☐
- Could this student return to school on an intermittent or full-time basis after his or her condition has stabilized?
Yes ☐ No ☐

TREATMENT FOR PSYCHIATRIC DIAGNOSIS

For students receiving treatment for psychiatric care, please include therapy schedule/treatment plan, and medications. An updated referral will be required for students being treated for full-time psychiatric care every 60 days. Evidence that the student is receiving ongoing treatment/therapy to return to an in-person learning environment must be evident.

- How often will the student receive therapy or treatment (excluding medication)?
Weekly ☐ Monthly ☐ Not determined ☐ No therapy recommended ☐
- What is the expected duration of the treatment/therapy? _____
- Can the student's therapy/treatment take place outside of school hours? Yes ☐ No ☐

MEDICATIONS

- Will the student take medication regularly for this medical condition? Yes ☐ No ☐
- Could this student return to school on an intermittent or full-time basis after his or her medication and condition has stabilized? Yes ☐ No ☐

If the student will be medicated, please provide information about each medication below. A list of medications can also be attached.

Name of medication (or attach list)	How long will this medication be taken?	Effects on student's ability to complete assignments and/or interact with teachers and other students

SCHOOL RE-ENTRY PLAN

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. ***I understand that should this student return to school prior to the "HHB End Date" notated on page 1 of this document, a written release with my signature will be required.***

Physician Printed Name & Stamp

Physician Signature

Date

Advanced Practice Provider (on behalf of licensed physician)

Date

*Note: The Georgia Composite Medical Board provided information on the following statute: O. C. G. A. 43-34-25, regarding Advanced Practice providers signing health forms for educational purposes. The law states:(e.1) Except for death certificates and assigning a percentage of a disability rating, an advanced practice registered nurse may be delegated the authority to sign, certify, and endorse all documents relating to health care provided to a patient within his or her scope of authorized practice, including, but not limited to, documents relating to physical examination forms of all state agencies and verification and evaluation forms of the Department of Human Services, the State Board of Education, local boards of education, the Department of Community Health, and the Department of Corrections. ****Note: The Advanced Practice Provider may only provide this service if the Physician delegates these duties and is in agreement with the diagnosis.***

This form is a total of 3 pages. All 3 pages must be completed for this referral to be reviewed.

Upon completion, please submit all documentation to the following department:

Family Services - Hospital Homebound
 166 Holly Smith Drive McDonough, GA 30253
 P: 770-957-3945 F: 470-483-0551
 Email: hospitalhomebound@henry.k12.ga.us