

Homebound Instruction Referral

Return Completed form to: Health Services, 1415 N. 26th St., St. Joseph, MO 64506 Email: lindseyubaldo@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 _____