Form 1-Medical/Psychiatric Referral for Adjustment of Educational Program

Revised 9/2014 - (2-page document)

Section 1 is to be completed by the **parent**, **nurse or homebound coordinator** at the attendance school. **Sections 2,3,4,5** are to be completed by the **physician. Section 6** can be completed by the **parent, nurse, teacher and/or physician**. **Section 7** is to be completed by the **nurse**. **ALL SECTIONS MUST BE COMPLETED BEFORE THE FORM WILL BE REVIEWED AND CONSIDERED.**

Some students need adjustments to their educational school program due to medical, physical or psychiatric conditions. In these unique instances, educational instruction may be provided in the home, hospital or treatment center. These instructional sites do not replicate actual classrooms and instruction is not a comparable alternative to daily school classroom instruction. Please complete this form for your patient who meets these distinctive conditions.

AN UPDATED MEDICAL REFERRAL WILL BE REQUIRED EVERY ONE TO THREE MONTHS DEPENDING ON THE NATURE AND EXTENT OFTHE CHILD'SPRESENTING CONDITION. AN UPDATED PSYCHIATRIC REFERRAL WILL BE REQUIRED EVERY MONTH. AN UPDATED REFERRAL MAY BE REQUIRED EVERY THREE (3) DAYS FOR INTERMITTENT STUDENTS with chronic conditions resulting in discontinuous attendance at school.

Send the **Medical/Psychiatric Referral, Teacher Application,** and **Teacher Acknowledgment** to the Home and Hospital Instruction Program via email at homeandhospital@cps.edu.

1. STUDENT INFORMATION (completed by the school nurse or school homebound coordinator)

Student's Name_____ **School Name**_____ **Area**_____

Today's Date_____ **Date of Birth**_____

Completed by_____ **CPS ID#**_____

Grade_____ **Parent or Guardian**_____

Home Phone Number_____**Cell Number**_____**Work Phone Number**_____

Home Address_____**Home Email Address**_____

2. PHYSICIAN INFORMATION (completed by the physician)

Physician's Name (Print) _____**Physician's License Number**_____

Physician's Specialty (area of practice)_____

Phone_____**Fax**_____**Physician's E-Mail**_____

Hospital(s) Affiliation(s)_____

Physician's Signature_____**Date Signed**_____

3. STUDENT ELIGIBILITY (completed by the physician)

Date of Most Recent Medical/Psychiatric Examination _____

Diagnosis Affecting School Attendance_____

Specify Ongoing Treatment and/Interventions for Medical or Psychiatric Condition(s) that preclude the student's attendance in school

☐ **Medical Diagnosis**_____ **Medications**_____

☐ **Psychiatric Diagnosis**_____ **Medications**_____

☐ **Motor/Orthopedic Diagnosis**_____ **Medications**_____

☐ **Chemical Dependency**_____ **Medications**_____

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Student Name_____**School**_____**Student ID**_____

☐ **Pregnancy Related Condition(s)**-Students who are pregnant are not eligible for homebound instruction unless there are complications associated with the pregnancy, such as toxemia or miscarriage.

Anticipated Delivery Date_____ **Actual Delivery Date**_____

Complications Associated with Pregnancy/Delivery?

☐ **Yes** ☐ **No (Please Check One Box) If Yes, specify the complications** _____

Health of the Baby_____

☐ **Postpartum/Aftercare-**Typically, students return to school after six (6) weeks of homebound instruction unless there were delivery complications, such as a Cesarean section.

4. TEACHING INSTRUCTIONAL DELIVERY SITE (COMPLETED BY THE PHYSICIAN). SELECT THE APPROPRIATE TEACHING SITE FOR THE STUDENT NAMED IN THIS REFERRAL.

☐Hospital Teaching

Facility _____
Name_____
Student is hospitalized for an acute or chronic medical or psychiatric

Start Date_____
End Date_____

☐Treatment Center Teaching

Facility _____
Name_____
Student has been placed by the family or a court system (New referral needs to be submitted monthly.)

Start Date_____
End Date_____

☐Homebound Teaching

Student is anticipated to be to be absent for ten (10) **or** more school days

Start Date_____
End Date_____

☐Intermittent Home Teaching

Student is chronically ill and may be absent periodically for ten (10**) or more** school days throughout the year

Start Date_____
End Date_____

5. TRANSITION BACK TO SCHOOL (completed by the physician)

☐ Return to school with **no restrictions**
☐ Restrictions are to be determined **after** return to school
☐ Return to school with designated restrictions (Specify the nature and extent of the restrictions)

Specify_____
_____

6. OTHER INFORMATION (Pertinent information which includes how the student's medical/psychiatric condition affects the student's ability to attend school)

_____
_____

7. SCHOOL NURSE INFORMATION (completed by school nurse)

I_____ **(print name of the school nurse) contacted the student's physician on** _____**(specify the date). In addition, I reviewed all sections of the Medical/Psychiatric Referral Form and consider the information to be complete and correct.**

I_____**(check one)** ☐ **agree** ☐ **disagree with the need for homebound instruction.**
Print Name

School nurse signature_____

Date physician contacted/interviewed_____

Date reviewed by school nurse_____