HENRY COUNTY SCHOOLS

166 Holly Smith Drive McDonough, GA 30253 P: 770-957-3945

Licensed Physician/Psychiatrist Statement and Medical Referral Form

(Note: This form must be completed by a physician or psychiatrist licensed by the State of Georgia.) ALL FIELDS MUST BE COMPLETED

Physician/Psychiatrist Name:_____

Name of Physicians Practicing Office/Hospital: _____ GA License #: _____

Address:_____ City: _____, GA Zip Code: _____

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

Student Information:

Student Name: _____
Last First MI

Date of Birth: _____ Gender: Male ☐ Female ☐

Parent/Guardian:_____
Last First MI

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

Physician/Psychiatrist Statement and Diagnosis

If the diagnosis is pregnancy, the student will not be approved for services until after the delivery, unless there are medical complications. Students diagnosed with a contagious disease will not be served while contagious.

Patient's Diagnosis: *(Note: Please include a description of the condition.)*

_____

RECOMMENDED HHB SERVICE TYPE:

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

☐ **INTERMITTENT - student should attend school as much as possible but may have periodic absences due to the documented diagnosis above**

Does the student have a Chronic Illness? Yes ☐ No ☐

Is/Was the Student Pregnant? Yes ☐ No ☐

Delivery Date: _____

Estimated Duration of HHB Services:

HHB Start Date: _____ *HHB End Date* (*Not to exceed 5/21/2021):* _____

Date of Initial Evaluation: _____ Date of Next Scheduled Appointment: _____

- Could the student attend school with accommodations? If so, describe. Yes ☐ No ☐

  Recommendations for Accommodations:

  _____

  _____

  _____

- Is the student unable to attend school for a minimum of ten consecutive school days?
  Yes ☐ No ☐
- Will the student be able to benefit from an instructional program during this time of confinement?
  Yes ☐ No ☐
- Could the student attend school regularly and receive HHB services on an intermittent basis?
  Yes ☐ No ☐
- Is the student confined to the home or hospital? Yes ☐ No ☐
- Is the student free from communicable diseases, such as flu or contagious airborne diseases?
  Yes ☐ No ☐
- Can instruction be provided to the student without endangering the health and welfare of the teacher or other students whom the teacher may contact? Yes ☐ No ☐

(NOTE: You may have to periodically verify that the student remains under your care and continues to qualify for the HHB services program.)

Treatment and School Reentry Plan

(Note: The following information is required to determine eligibility for HHB services and must be completed by the licensed physician or licensed psychiatrist who is currently treating the student for the diagnosis presented.)

- What is the scheduled frequency of treatment/therapy for this student?
  ☐ Daily ☐ Weekly ☐ Monthly
- What is the expected duration of the treatment/therapy? _____
- Will the student take medication? Yes ☐ No ☐

Name of medication (**or attach list**)	Effects on student's ability to comprehend	Effects on student's ability to complete independent assignments	Effects on student's ability to relate to teachers and other students

- Could this student return to school on an intermittent basis after his or her medication and condition is stabilized? Yes ☐ No ☐
- Can this student come into contact with other students? Yes ☐ No ☐

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 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 - our office must have all pages in order to process this referral.

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

*Please take note of our new location and phone number above.
Completed forms may be scanned and emailed to the following individuals:
Leslie.Cheatwood@henry.k12.ga.us or Nancy.Steele@henry.k12.ga.us