

Licensed Physician/Psychiatrist Statement and Medical Referral Form

Chattooga County Special Education Department

13234 Highway 27

Summerville, Georgia 30747

Phone: 706-822-9902 Fax: 706-822-9906

(Note: This form must be completed by a physician or psychiatrist that is state licensed. Form must be faxed or mailed back to the school.)

Physician/Psychiatrist Name: _____

License #: _____

Address: _____

Phone Number: _____ Fax: _____

Student Information

Student Name: _____

Last

First

MI

Address: _____

M F Date of Birth: _____

Parent/Guardian: _____

Last

First

MI

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

Physician/Psychiatrist Statement and Diagnosis

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

Estimated Duration of HHB Services:

Starting Date: _____

Ending Date: _____

Date of Initial Evaluation: _____

Date of Next Scheduled Appointment: _____

Physician's Statement: *(Note: Please answer the following questions keeping in mind that the least restrictive environment is preferred.)*

- 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 with accommodations? If so, describe. Yes No

Recommendations for Accommodations:

Could the student attend school regularly and receive HHB services on an intermittent basis as needed?

Yes No

Is the student confined to the home or hospital and full-time HHB services are recommended?

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 of the teacher or other students whom the teacher may contact?

Yes No

(NOTE: You may periodically have to 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

Medications student will take for diagnosis:

Name of Medication	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.

Physician Printed Name

Date

Physician Signature

Date