THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA
EXCEPTIONAL STUDENT EDUCATION
1960 LANDINGS BOULEVARD, SARASOTA, FL 34231
(941) 927-9000
HOMEBOUND OR HOSPITALIZED PROGRAM

MEDICAL REFERRAL

The Homebound Program is for those students who have a "medically diagnosed physical or psychiatric condition which is acute or catastrophic in nature, or a chronic illness, or a repeated intermittent illness due to a persisting medical problem and which confines the student to the home or hospital, and restricts activities for an extended period of time" (State Board of Education Rule 6A-6.03020). Eligibility must be determined annually and services will follow the regular school year calendar. Homebound services are meant as a short-term intervention and do not in any way supplant attendance in a regular school for an extended period of time.

Instructions: All Medical Referral Forms must be faxed directly from the physician's office to the student's school. Incomplete forms will be returned. Returned forms will delay the student's possible placement into the Homebound or Hospitalized Program. If during treatment the physician needs to extend the expected date of return to school, the physician may do so by informing the school of the extension in writing.

Patient Name _____ DOB _____

Medical or Psychiatric Diagnosis (Print. Attach additional sheets if necessary.) _____

_____

_____

Physician/Psychiatrist Name (Print) _____

Address _____

Phone _____ Fax _____

Eligibility

The licensed physician must certify that the student meets all of the following criteria for eligibility. Students who do not meet all of the minimum eligibility criteria listed below will not be eligible for the Hospital/Homebound Instructional Program.

All questions must be answered and initialed by the physician in order to certify eligibility.

YES	NO	INITIAL	
☐	☐	_____	1. Is the student expected to be absent from school due to a physical or psychiatric condition for at least fifteen consecutive school days or 8 on a block schedule? **OR**
☐	☐	_____	2. Is the student expected to be absent from school for at least 15 school days, which need not run consecutively, due to a chronic condition?
☐	☐	_____	3. Is the student free from communicable diseases?
☐	☐	_____	4. Will the student be able to participate in and benefit from an instructional program?
☐	☐	_____	5. Is the student under medical care for illness or injury which is acute, catastrophic, or chronic in nature?
☐	☐	_____	6. Can the student receive instructional services without endangering the health and safety of the instructor or other students the instructor may come in contact?
☐	☐	_____	7. Could the student attend school with accommodations (e.g. second set of books at home, use of a wheelchair, etc.)?
☐	☐	_____	8. Could the student attend school regularly and receive Homebound or Hospitalized services on an intermittent basis?
☐	☐	_____	9. Is the student CONFINED TO HOME OR HOSPITAL and FULL TIME HOMEBOUND OR HOSPITALIZED services are recommended?

Students entering the Homebound or Hospitalized Program will be placed in the most restrictive educational and social environment where the student will not have physical contact with their peers during the school day.

☐	☐	_____	10. Do you recommend the student be placed in this most restrictive environment?

MEDICAL REFERRAL FORM

Patient Name _____ DOB _____

Estimated Duration on Homebound or Hospitalized

Starting Date _____ Expected School Return Date (mandatory) _____

Treatment Plan and Other Information

Treatment and school reentry plan: The following information is required to determine eligibility for Homebound or Hospitalized Program services and must be completed by the treating physician.

1. What is the prognosis for this student? _____
2. What is the therapy schedule for this student? ☐ Daily ☐ Weekly ☐ Monthly
3. What is the expected duration of treatment/therapy? _____
4. Will the student be taking medication? ☐ Yes ☐ No
   - *a.* If so, list the name(s) of medication _____
     - *i.* Effects on student's ability to comprehend instruction _____
     - *ii.* Effects on student's ability to complete independent assignments _____
     - *iii.* Effects on student's ability to relate to teachers and other students _____
5. Could this student return to school on an intermittent basis after his/her medication and/or condition is stabilized?

   ☐ Yes ☐ No
6. Can this student come into contact with other students? ☐ Yes ☐ No
7. List any accommodations needed to enable this student to return to school _____

   _____

The Homebound or Hospitalized Program is designed to be a temporary educational program to assist children who are unable to attend school for medical or psychiatric reasons. For additional information contact the ESE Liaison or School Counselor at the student's school.

Physician's Certification: I certify that this student is under my care and treatment for the aforementioned illness. My recommendation has been made based on the medical needs of the patient, keeping in mind that the least restrictive environment is preferred.

_____ _____

Physician/Psychiatrist Signature Date