**IREDELL-STATESVILLE SCHOOLS**

**Physician’s Referral for Homebound Services/Instruction**

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| --- | --- | --- | --- | --- |
| Student’s Name |  |  | ID |       |
| DOB |       |  | Grade |       |  | School |       |
| **NOTE TO PHYSICIAN:** This student is being considered for homebound instruction. Your medical advice is necessary in determining whether this service is required. Please answer the questions below. Your prompt reply will be appreciated, as we are unable to make a decision without your input. |
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| **PERTINENT MEDICAL INFORMATION WHICH WOULD IMPACT EDUCATIONAL NEEDS** |
| 1. Specify medical diagnosis which prevents student from attending school:       |
| 2. Is student free from contagion, which would be harmful to school personnel? Yes No |
| 3. Prognosis:       |
| 4. Clarify how this interferes with school attendance (be specific):       |
| 5. If homebound services are expected to last more than 12 weeks, what is the date of the re-evaluation? Explain why the services will exceed the 12 week period. |
| 6. How often do you see the patient?      **\*Medical updates will be required every 30 days for prolonged cases of eight weeks or more to determine continuation of** **Homebound Services. If homebound will last more than 12 weeks,** a new homebound referral form will need to be completed upon re-evaluation by the supervising physician.  |
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| How long do you anticipate the student will be unable to attend school? Please do not indicate indefinitely or undetermined. |      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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|  |  |  |
| **Physician’s Name *(please print/stamp*)** |  | **Physician’s Signature** |
|  |
| Office Phone |  |  |  |  |
| Office Fax |
| Date of office visit |  |  |  |  |

 **HB Form (3)**