Home/Hospital Instruction: *Physician's Referral*

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HOME/HOSPITAL PHYSICIAN'S REFERRAL

Date: ______________________

To: REFERRAL PHYSICIAN ______________________________ Phone: __________________ Fax: ____________________

From: Allyson Rude Azevedo, Administrator/ Alternative Programs, Travis Unified School District

Re: ____, student School: ____________________________________

The above named student is requesting or has been referred for Home/Hospital Instruction. Home/Hospital Instruction will be provided for students who have **temporary (more than two weeks)** or **chronic disabling conditions** in which classroom attendance is not feasible. Home/Hospital Instruction will be initiated upon receipt of this form from the student's attending physician.

> ***IMPORTANT- Please consider the following:***
> Although every effort will be made to ensure a quality instructional program for the student, in most cases **the classroom experience cannot be fully replicated.** Other reasonable measures (shortened day, support services, specific accommodations) in the school setting could help this student through a difficult time, and are *often preferable* to removal from current setting. **Please contact Ms. Rude at 437-8166 to discuss alternatives**.

In order to initiate Home/Hospital instruction, the following information must be completed and returned/faxed to Allyson Rude Azevedo:

1. Reason for MEDICAL PLACEMENT recommended by attending physician:

- ❑ **Missing class instruction due to frequent hospitalizations for tests or treatment**
- ❑ **Post-op recovery is needed**
- ❑ **Fragile health condition after accident/physical trauma**
- ❑ **Other (explain here or with attachment)** ____

2. Expected duration of Home/Hospital Instruction (must be completed to begin program —may be amended):

Start Date ____/____/____ **Exit Date** ____/____/____ **Review** ____/____/____

3. Is the student in a contagious/communicable state?

❑ **No.** ❑ **Yes. (Preventive protocol information for the specific disease must be provided. Please attach.)**

4. Specific restrictions (time, movement, etc.) of condition ____

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Name of Physician/Medical Practitioner ____ **Phone** ________________________

Facility Name ____ **Address** ____

Physician's Signature ____ **Date of Referral** ______________________