Student Support Services
Health Services
HHI (HOME HOSPITAL INSTRUCTION)
975 North D Street
Stockton, CA 95205
(209) 933-7060

APPLICATION FOR PSYCHIATRIC REFERRAL

CHECKLIST

Please complete the attached Psychiatric Referral form and include the following:

- □ Completed SUSD Authorization for Release of Health Information
- □ Completed agency Release of Information (ROI) authorizing communication with Stockton Unified School District
- □ Copy of Treatment Plan
- □ Other relevant information, as available; i.e., assessments, psychiatric evaluation, psychiatric hospital discharge documents, IEP, 504 Plan, etc.
- □ Student's Transcript & Class Schedule (high school)
- □ Student Profile/Information page

APPLICATION MUST BE FILLED OUT COMPLETELY BEFORE IT CAN BE PROCESSED

Applications are accepted via in person or email.

EMAIL THIS FORM TO:
Jserena@stocktonusd.net
Attn: HHI (Home Hospital Instruction)

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PSYCHIATRIC REFERRAL APPLICATION

(ONLY COMPLETED APPLICATIONS WILL BE PROCESSED)

This request is valid for the current school year only _____

☐ Initial Request ☐ Extension Request (If extension, initial request date: _____)

Student's Information

Last name_____ First name_____ M F

D.O.B._____/_____/_____ Grade_____ Student ID_____ Counselor/ Teacher _____

School_____ Phone Number _____

Parent/Guardian _____ Phone Number _____

Address _____ City _____ Zip _____

Does student have a current IEP? Yes No Eligibility _____

504 Plan? Yes No Condition related to the 504 Plan _____

The following modified programs or other educational options have been tried (please check all that apply):

- ☐ Enrolled in a shortened school day.
- ☐ Enrolled in an Independent Study Program allowing the student to complete course work independently, at home, and review work once a week with a teacher for a grade.
- ☐ Developed and implemented a Section 504 Plan to accommodate student needs through program modifications (ie: modify a class schedule, adjust placement of a student within a classroom, increase/decrease opportunity for movement, quiet area to complete work, approve early dismissal for service agency appointments, etc.)
- ☐ Identified as eligible for special education services and an Individualized Education Program (IEP) was developed to consider the student's abilities, educational needs, and the appropriate placement and services.

HHI (HOME HOSPITAL INSTRUCTION)

Consistent with California laws, five (5) hours per week of instruction will be provided to your child. A responsible adult, 18 years of age or older, must be present when the teacher is in the home.

By signing, Parent/Legal Guardian and/or Student Authorizes the Doctor to Release Information to Stockton Unified School District.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Student Signature **Date**

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This request is valid for the current school year only _____

Student Name _____ **D.O.B.** _____

Psychiatrist's Certification

PSYCHIATRIST: A request for **temporary** Home Hospital Instruction has been made for the above-named student. California Education Code §44873 requires that a licensed California physician/psychiatrist file a statement which includes a medical diagnosis.

Is the student physically capable of attending classes on his/her school campus with accommodations to meet their physical or other needs? **YES** **NO**

If yes, please list accommodations _____

_____

If no, please complete the information below:
Clinician/Case Manager: _____
Psychiatrist: _____
Diagnosis: _____
Summary of the treatment plan (as implemented by psychiatrist and clinician):

_____

_____

What aspects of the treatment plan are being implemented to enable the student to return to school?

_____

_____

What medication(s) and dosage are the student currently prescribed?

_____

Has the student had any crisis visits in the past 12 months? **YES** **NO**
If yes, please describe: _____
Has the student been hospitalized psychiatrically in the past 12 months? **YES** **NO**
If yes, please describe: _____
Is the student a danger to self or others? **YES** **NO**
If yes, please describe: _____

Limitations, restrictions or precaution the school should be aware of: _____

_____

Date student can return to regular school (required): _____

If the return date is unknown, will the return date be a minimum of 2 weeks from the date you sign this form? YES NO

Psychiatrist's Signature _____ **Date** _____

Psychiatrist's Name (Print) _____ **Phone** _____

Fax _____

Address _____ **City** _____ **Zip** _____