Student Support Services
HHI (HOME & HOSPITAL INSTRUCTION)
1144 E. Channel Street, Room #104
Stockton, CA 95205
(209) 933-7020, Ext. 2280 Fax (209) 469-4519
BE N. Boonsalat - Email: bboonsalat@stocktonusd.net

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, etc.
- □ Student's Transcript & Class Schedule (7th-12th grade)
- □ Student Profile/Information page (1st-12th grade)

APPLICATION MUST BE FILLED OUT COMPLETELY BEFORE IT CAN BE PROCESSED

Applications are accepted via in person, by fax or email.

PLEASE FAX OR EMAIL THIS FORM TO:
TO: (209) 469-4519 /bboonsalat@stocktonusd.net
Attn: BE Boonsalat

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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.

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**

(Rev 07/08/19 BB)

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PSYCHIATRIC REFERRAL APPLICATION

(ONLY COMPLETED APPLICATIONS WILL BE PROCESSED)

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** _____

(F

SUSD
Stockton Unified School District

HEALTH SERVICES
975 North D Street
Stockton, California 95205
(209) 933-7060 Ext. 2390 • Fax (209) 933-6520

Authorization for Release of Health Information

A. STUDENT/ PATIENT INFORMATION:

Name: _____ Date of Birth: _____
LAST FIRST MI

B. INFORMATION TO BE RELEASED FROM:

- ____ _____ School District
- ____ California Children's Services (CCS)
- ____ Medical Therapy Unit
- ____ Valley Mountain Regional Center
- ____ St. Joseph's Medical Center
- ____ UCSF Medical Center
- ____ Children's Hospital Oakland
- ____ San Joaquin General Hospital
- ____ Dameron Hospital
- ____ Kaiser Permanente
- ____ Public Health Services
- ____ Mental Health Services
- ____ San Joaquin County Behavioral Health

____ Physician/Clinic/Other: _____

____ Physician/Clinic/Other: _____

C. INFORMATION TO BE RELEASED TO AND USED BY STOCKTON UNIFIED SCHOOL DISTRICT:

School/Department _____ Contact Person _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

D. PURPOSE OF THE REQUESTED INFORMATION:

- ____ Authorization forwarded at the request of Parent/Legal Guardian
- ____ Assist in determining most appropriate school education program / learning accommodations
- ____ Other: _____

E. TYPE / DESCRIPTION OF INFORMATION REQUESTED:

- ____ Immunization Record
- ____ Physician Orders
- ____ History and Physical
- ____ Consultation Reports
- ____ Operative Reports
- ____ Lab Results/X-ray Reports
- ____ Discharge Summary
- ____ Other: _____
- ____ Ambulatory Clinic Summary
- ____ Appointment Dates/Times
- ____ Mental Health Records

For the time period of _____ to _____.

F. SIGNATURE AUTHORIZING RELEASE OF INFORMATION:

By signing below, I understand that the information released may include information regarding treatment, hospitalization, or outpatient care, including psychological/psychiatric impairment, drug abuse, alcoholism, AIDS, or HIV tests, unless otherwise excluded here: _____

I also understand that the school district is responsible for maintaining confidential files for access and review by involved educational staff only. Academic, psychological and health records are exchanged among California public schools.

I have read and understand the "Authorization Restrictions and Rights" on the backside of this form which includes my right to refuse to sign this authorization, to revoke this authorization, and to receive a copy of this authorization.

If you authorize disclosure of information to a person or entity that is not legally required to keep it confidential, the information may be re-disclosed and may no longer be protected by state or federal law.

DURATION: Unless revoked, this authorization will expire 1 year from date of signature, unless otherwise specified here:_____

_____ _____
Signature of Parent / Legal Guardian **Relationship** **Date**

_____ _____
Signature of Witness **Date**

Authorization Restrictions and Rights

- Signing this authorization is voluntary. You can refuse to sign this authorization. Refusing to sign this authorization will not affect Stockton Unified School District's commitment to providing a quality education for your child; however, refusing to sign may inhibit the school's ability to implement an optimal plan of education, learning accommodations and/or health care plan for your child.

- This authorization may be revoked at any time. To revoke this authorization, you must provide the organization or individual listed in Section B of this form, with a written request to revoke the authorization. Any information disclosed before your written revocation is received may be used as previously permitted.

- You have the right to receive a copy of your "Authorization for Release of Health Information." If you request it, you will receive a copy of this authorization after you sign it.

- Stockton Unified School District is responsible for maintaining confidential files for access and review by involved educational staff only. Academic, psychological and health records are exchanged among California Public Schools. No further disclosure of this information, by Stockton Unified School District, should be done without specific, written and informed release by parent/legal guardian.

- You may inspect or copy the information to be disclosed, as provided in CFR 164.524.

This document was translated to parent/legal guardian into _____. This document was read to the patient verbatim and questions, if any, were answered prior to signature.

Translated by: _____ _____

Signature Date

AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC, ALCOHOL, SUBSTANCE USE RECORDS, HIV RELATED INFORMATION (RELEASE OF INFORMATION) – ROI

PATIENT INFORMATION :

Patient/Client Name _____

DOB_____SSN_____Telephone_____

Maiden Name/Other Name Used in the Past_____

Dates of treatment covered by this authorization: From _____ To _____

EXPLANATION:

This authorization conforms to requirements of State and Federal laws governing release and receipt of Protected/Patient Health Information (PHI).

AUTHORIZATION:

I hereby authorize the following healthcare provider/agency to disclose information from my records to the recipient(s) listed below, even though such information is otherwise confidential and/or privileged. I hereby authorize reciprocal release from my records to the recipient(s) listed below ☑

FROM: Name *San Joaquin Co. Behavioral Health SVCS.* Phone *(209) 468-2385*

Address *1414 N. California St.*

City, State, Zip Code *Stockton, Ca 95202*

TO WHOM: Name *Stockton Unified School District, Mental Health & Behavior Support Services* Phone *(209) 933-7000*

Address *1141 Lever Blvd*

City, State, Zip Code *Stockton, CA 95206*

PURPOSE(S): State reason records are being requested (Please select one from the list)

◯ Continuing Health Care ◉ Communication

◯ View My Records ◯ Receive a Copy of My Records

◯ Other (please describe, be specific) _____

INFORMATION WHICH MAY BE RELEASED:

I give **special authorization** to release information regarding:

☑ Psychiatric/Mental Health ☐ Substance Abuse ☐ HIV Information

Disclosure shall include the following types of information. Check all that apply.

☑ Evaluations/Assessments/Treatment Plans
☐ Inpatient Records
☐ Drug Testing Results
☐ Financial Records
☐ ASAM Results
☑ Other (please be specific)_____

☑ Lab Reports
☑ Outpatient Records
☑ Crisis Records
☑ Prescription/Medication Log

If special form is submitted for doctor to complete (please specify name of form) _____

EXCEPTION(S): Information That You Do Not Want Released (be specific):

I understand that such information cannot be released without my special consent, except when required by law and that all restrictions contained in this authorization as to use, transfer, or disclosure of such information apply to such records.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to San Joaquin County Behavioral Health Services. I understand that the revocation will not apply to information that has already been released in response to this authorization.

DATE OF EXPIRATION (not to exceed one year from date of signature)**:**_____

PROHIBITION ON USAGE, TRANSFER, OR REDISCLOSURE OF INFORMATION:

Except as required by state or federal laws, use of information released for other than the stated purpose or redisclosure or transfer of this information to any person or entity not named herein is prohibited. An additional written authorization must be obtained for any proposed new use of the information or its redisclosure or transfer of such information. Authorized information may be subject to redisclosure by the recipient and no longer protected by the privacy regulations.

RIGHT OF CLIENT TO RECEIVE A COPY OF AUTHORIZATION:

I understand that I have the right to receive a copy of this signed authorization.

I have received a copy of this authorization. ☑ Yes ☐ No

I understand that authorizing the use or disclosure of the information identified above is voluntary. San Joaquin County Behavioral Health Services will not condition treatment, payment, enrollment, or eligibility of benefits on whether I sign this authorization.

_____ Date_____

Signature of patient/client or legal representative*

*If signed by legal representative, authority/relationship to patient_____

Verification of client's ID at point of signature was completed and confirmed by my signature:

Witness (Staff name)_____

MINORS: By federal regulations in drug/alcohol abuse or HIV/AIDS related material then both the patient/client and parent, guardian or other person authorized to act by state law in his/her behalf is required.

NOTES: Where minor may consent to treatment by state law, only minor must sign.