



A COPY OF IMMUNIZATION RECORDS ARE REQUIRED WITH THIS REFERRAL

PSYCHIATRIC REFERRAL FOR HOME INSTRUCTION

Carlson Home Hospital School
10952 Whipple St., No. Hollywood, CA 91602
Phone: (818) 509-8759 FAX: (818) 505-0246

Student Information

Last Name _____ First Name _____ M F
 DOB ___ / ___ / ___ Gr. ___ Student Language _____ Parent/Guardian Language _____
 Address _____ City _____ Zip _____
 Home Phone () _____ - _____ Cell Phone () _____ - _____ Work Phone () _____ - _____
 Parent/Guardian _____ Parent Email Address _____
 Student Email Address _____ School of Attendance _____
 Last date of attendance at current School ___ / ___ / ___
 Does student have a current IEP? Yes No Eligibility _____ 504 Plan? Yes No

This section to be completed by the school of attendance **Principal/Designee**. The following accommodation(s) have been tried: (check all that apply):

- Enrolled in a shortened school day.
- Enrolled in an Independent Study Program provided by the student’s cumulative record carrying school, allowing the student to complete course work independently, at home.
- 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 appts., 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.
- Other: _____

Principal’s Signature (or designee) _____ **Date** ___ / ___ / ___
Print Name and Title _____

IMPLEMENTATION OF SERVICE

Face-to-Face Home Instruction will provide students in grades TK–5/6 on the General Ed Curriculum or in grades TK–12 on the Alternate Curriculum five (5) hours of instruction per week. Instruction is offered in two (2) basic subject areas. English Learners and Standard English Learners will be provided additional instruction in ELD/MELD. A responsible adult (18 years of age or older) identified in writing by educational rights carrier must be present when the teacher is in the home.

By signing this authorization for service, the parent/guardian is agreeing to the following:

- If the student is eligible, educational services will be temporarily provided by the Carlson Home Hospital School for a maximum of 90 calendar days.
- The student will be temporarily disenrolled from his/her regular school of attendance (cumulative record carrying school) during the period he/she is receiving Carlson services. Grades and marks will be reported to the cumulative record carrying school.
- Educational information will be accessed and used to plan and provide an appropriate educational program for the student.
- Permission to provide services or access school records may be revoked via written parent/guardian request at any time.
- Carlson provides home instruction between the hours of 8:00 AM and 7:00 PM. No specific schedule nor teacher can be guaranteed.

PARENT/LEGAL GUARDIAN AUTHORIZATION TO RECEIVE/RELEASE MEDICAL AND ACADEMIC INFORMATION AND TEMPORARILY TRANSFER EDUCATIONAL DUTIES:

Parent Signature _____ Date __/__/__

California Licensed Psychiatrist must complete page 3 to authorize service.

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Student Name _____ D.O.B. ____/____/____

PSYCHIATRIST: A request for temporary Home Instruction has been made for the above-named student. This referral form (page 2 of 2) must be completed by a California licensed psychiatrist in order to be considered and must include a diagnosis and the length of time the student is anticipated to be confined to the home.

Psychiatrist's Statement

Is student capable of attending classes on his/her school campus now, with accommodations to meet their emotional needs? Yes No

If yes, student does NOT qualify for home instruction. List accommodations to be used at the student's current school campus:

If no, complete the information below:

Diagnosis or ICD/DSM code: Summary of therapeutic plan:

What medication(s) is/are the student currently prescribed? Is the student a danger to self or others: Yes No

Explain:

Why is the student unable to attend school?

This section to be completed by a California licensed psychiatrist:
Estimated date student may return to school (*Specific* date required, not to exceed 90 days)

Signature	MD	Date
Print Name	Phone	
Print Title	Fax	
Address	City	Zip

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