Chicago Public Schools | OFFICE FOR STUDENTS WITH DISABILITIES

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Referral for Adjustment of Education Program

Some students need adjustments to their educational school program due to medical, physical or psychiatric conditions. In these unique instances, instruction may be provided in the home, hospital or treatment center setting. Please complete this form for your student/patient who may meet these distinctive conditions. General education students will receive one (1) hour of education services in the home or hospital setting. Students with an active IEP will receive no less than one (1) hour of education services in the home or hospital setting. In order to offer a continuum of services to students who have a diagnosed medical or psychiatric condition, school teams will meet to discuss and determine the amount and frequency of services. For students with active IEPs, the IEP team is the school team that determines eligibility for HHIP services and, if eligible, the amount and frequency of services.

Section 1 is to be completed by the **parent**, **nurse or homebound coordinator** at the attendance school.

Sections 2, 3 and 4 are to be completed by the **Physician. These sections may be completed by a physician licensed to practice medicine in all of its branches, licensed physician's assistant or licensed advanced practice nurse.**

Section 5 is to be completed by the **School Nurse**.

AN UPDATED MEDICAL REFERRAL WILL BE REQUIRED EVERY ONE TO THREE MONTHS DEPENDING ON THE NATURE AND EXTENT OF THE CHILD'S PRESENTING CONDITION. ALL SECTIONS MUST BE COMPLETED BEFORE THE FORM WILL BE REVIEWED AND CONSIDERED.

Send the **Medical Referral, Teacher Application,** and **Teacher Acknowledgment** to the Home and Hospital Instruction Program via the Google form.

1. STUDENT INFORMATION (completed by the School Nurse or School Homebound Coordinator)

Student's Name_____ **School Name**_____
Today's Date_____ **Date of Birth**_____
Completed by_____ **CPS ID#**_____
Grade_____ **Parent or Guardian**_____
Home Phone Number_____ **Cell Number**_____ **Work Phone Number**_____
Home Address_____**Home Email Address**_____

2. PHYSICIAN INFORMATION (completed by the physician licensed to practice medicine in all of its branches, licensed physician's assistant or licensed advanced practice nurse)

Physician's Complete Name (Print) _____**Physician's NPI** _____
Physician's Specialty (area of practice)_____
Phone_____**Fax**_____**Physician's E-Mail**_____
Hospital(s) Affiliation(s)_____
Physician's Signature_____**Date Signed**_____

3. STUDENT ELIGIBILITY (completed by the physician licensed to practice medicine in all of its branches, licensed physician's assistant or licensed advanced practice nurse)

Date of most recent medical examination _____
Diagnosis affecting school attendance_____

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Pertinent information which includes how the student's medical/psychiatric condition affects the student's ability to attend school

_____

_____

Specify ongoing treatment and/interventions for condition that precludes the student's attendance in school

_____

Specify all recommendedlimitationsthat would preventstudent from receiving daily instruction

_____

_____

Medications_____

Pregnant and Parenting Students:

☐ **Pregnancy-Related Condition(s)**- Students who are pregnant are not eligible for homebound instruction unless there are complications associated with the pregnancy, such as toxemia or miscarriage.

Anticipated Delivery Date_____ **Actual Delivery Date**_____

Complications Associated with Pregnancy/Delivery? (Please Check One Box) ☐ **Yes** ☐ **No**

If yes, specify the complications_____

Health of the Baby_____

☐ **Postpartum/Aftercare -** Typically, students return to school after six (6) weeks of homebound instruction unless there were delivery complications, such as a Cesarean section.

4. TEACHING INSTRUCTIONAL DELIVERY SITE (Completed by the Physician.) SELECT THE APPROPRIATE TEACHING SITE FOR THE STUDENT. INDICATE THE ANTICIPATED DURATION OF THE STUDENT'S ABSENCE. HOMESCHOOL.)

☐ **Hospital Teaching**	☐ **Treatment Center Teaching**	☐ **Homebound Teaching**	☐ **Intermittent Home Teaching**
Facility _____ **Name**_____ Student is hospitalized for an acute or chronicmedical condition	**Facility** _____ **Name**_____ Student has been placed by the district or a court system	Student is anticipated to be to be absent	Student is chronicallyill and may be absent periodically throughout the year
Start Date_____ **End Date**_____	**Start Date**_____ **End Date**_____	**Start Date**_____ **End Date**_____	**Start Date**_____ **End Date**_____

5. SCHOOL NURSE INFORMATION (completed by School Nurse)

I, _____ ,(print name of the school nurse) reviewed all sections of the referral form and consider the information to be complete and correct.

Date reviewed by School Nurse_____

School Nurse's signature_____