Stockton Unified School District

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

(ALL highlighted areas must be filled out in order to be considered complete)

Applications are accepted via in person or email.

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

Stockton Unified School District

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PSYCHIATRIC REFERRAL APPLICATION
ONLY COMPLETED APPLICATIONS WILL BE PROCESSED

(ALL highlighted areas must be filled out in order to be considered complete)

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 I.D _____ 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.

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Student Signature **Date**

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PSYCHIATRIC REFERRAL APPLICATION

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This request is valid for 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** _____

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 EXCHANGED WITH 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