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Office of Home and Hospital Teaching

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PSYCHIATRIST/ PSYCHOLOGIST VERIFICATION: Emotional Conditions

This form is used to obtain the recommendation of a **licensed psychiatrist, licensed psychologist, or licensed psychiatric mental health nurse practitioner** to initiate Home and Hospital Teaching (HHT) services for students who have an emotional condition that renders them unable to attend school. School personnel may need to contact the referring physician for additional information necessary to determine service need. Services may be denied if the referring psychiatrist, licensed psychologist, or licensed psychiatric mental health nurse practitioner cannot be reached within three days of the initial attempt to make contact. Your signature below provides authorization for the physician or clinician to **release information** to PGCPS staff and for PGCPS staff to **release information** to the physician or clinician.

Parent Signature: _____ Date: _____

Student Information:

Student Name: _____ Date of Birth: _____

School Name: _____ Student Grade: _____

Student PGCPS ID#: _____

Information for Mental Health Provider Consideration:

- Home and Hospital Teaching is for students who are unable to attend school due to a physical or emotional condition during a period of convalescence or treatment in a medical institution, therapeutic treatment center, and/or student's place or residence.
- Home and Hospital Teaching is for students experiencing hospitalization or convalescence that leads to continuous absence of 20 or more school days or for students experiencing chronic conditions that lead to recurring, intermittent absences of 3 or more consecutive school days.
- In many cases, the school team may be able to work with the family of a student experiencing an emotional condition to accommodate the student in school. Parents/guardians should consult with school teams about available accommodations.
- Accommodations that may be available in some cases should be discussed by the parent/guardian and the school team.
- Home and Hospital Teaching is not intended to replace school attendance (35 hours of instruction per week).
- School systems are not permitted to use Home and Hospital Teaching as an alternative setting while awaiting a change in placement.
- Approved students receiving Home and Hospital Teaching receive approximately 6 hours of instruction per week.
- A new verification form is required for continuation of service beyond 60 calendar days.
- Additional pertinent medical information regarding the student's case may be attached for review.
- Prince George's County Public Schools **does not offer online or virtual school** instead of regular school attendance.

Medical Information for Home & Hospital Teaching Determination

1. **Diagnosis and DSM-5-TR or ICD-10 code(s) that prevent the student from attending school for 20 or more days.** dfkdkfldjd	
2. I am the provider who provides medication management for the above-named student.	◯ **NO** ◯ **YES**
3. I am the provider who provides mental health/behavioral therapy for the student named above.	◯ **NO** ◉ **YES**
4. Date of first appointment with the above-named student.	dfdfsd

Student Name: _____

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5. Date of most recent appointment with the above-named student.	
6. Based on the condition in question #1, the above-named student is…	☐ Unable to attend school for 20 or more consecutive days ☐ Able to attend school intermittently as health permits

7. If the student is **UNABLE TO ATTEND SCHOOL** explain how the student's emotional condition and/or treatment prevents the student from attending school for 20 or more days.

Recommendations to assist the student with returning to school

☐ Accommodations/Modifications to student workload (Provide Examples)

☐ Accommodations/Modifications to school day (Provide Examples)

☐ Other:

8. If the student can **ATTEND INTERMITTENTLY AS HEALTH PERMITS** explain how the student's emotional condition and/or treatment may affect the student's attendance or functioning at school.

Recommendations to support school attendance and participation within the school building

☐ Accommodations/Modifications to student workload (Provide Examples)

☐ Accommodations/Modifications to the school day or schedule (Provide Examples)

☐ Check-ins with Professional School Counselor or School Mental Health Clinician

☐ Other:

9. Is the student currently taking medication?	☐ **NO** ☐ **YES**
10. Provide the names of the medication and dosage.	
11. Has treatment of this emotional condition required hospitalization or time in a residential facility?	☐ **NO** ☐ **YES** If yes, provide names of facilities and dates of stays:

Student Name: _____

PGCPS

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12. I have provided a copy of the treatment plan and therapy goals for this student to be submitted with this form. **NOTE: A treatment plan with therapy goals must be submitted with this form.**	◯ **NO** ◯ **YES**
13. Date HHT services should begin:	
14. Anticipated **duration** of service **(WEEKS ONLY)**: **NOTE: If approved, a new form must be submitted every 60 days.**	

Health Care Provider Verification

Health Care Provider's Name and Title (Print):	
Health Care Provider:	◯ Licensed Psychiatrist ◯ Licensed Psychologist ◯ Licensed Psychiatric Mental Health Nurse Practitioner
License Number:	Contact Phone Number:
Email Address (For School Psychologist Consult):	

This form is valid for 60 days from the date of physician's signature.

Health Care Provider's Signature: _____ Date: _____

Review by PGCPS Office of Psychological Services ONLY

The Office of Psychological Services has reviewed this referral for Home and Hospital Teaching and is indicating the following:

☐ School Psychologist reviewed the referral documentation and SUPPORTS the recommendation for HHT services.
☐ Office of Psychological Services Supervisor/Coordinator SUPPORTS the recommendation of HHT services.

☐ School Psychologist reviewed the referral documentation and DOES NOT support the recommendation of HHT services.
☐ Office of Psychological Services Supervisor/Coordinator DOES NOT support the recommendation of HHT services.

Signature PGCPS Office of Psychological Services Supervisor/Coordinator: _____ **Date:** _____