A COPY OF IMMUNIZATION RECORDS ARE REQUIRED WITH THIS REFERRAL

LOS ANGELES UNIFIED SCHOOL DISTRICT

Carlson Home Hospital School

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

PSYCHIATRIC REFERRAL FOR HOME INSTRUCTION

Student 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** _____

Do you have Internet Access? ☐ **Yes** ☐ **No** **Student Email Address (Gr. 6-12)**_____

School of Attendance _____ **Phone** ( ) _____ **Last date of attendance** _____

School of Residence _____

Does student have a current IEP? ☐ **Yes** ☐ **No** **Eligibility**_____ **Does student have a current 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 (LAUSD Bulletin M-128.0), 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

Carlson Home Online Academy (CHOA) Home Instruction will provide students in grades 6/7–12 on the General Ed Curriculum up to 15-20 hours of instruction per week in up to five (5) subject areas. Students eligible for CHOA may be provided face-to-face home instruction for five (5) hours of instruction in 2 basic subject areas per week on a case-by-case basis in lieu of participating in CHOA.

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 2 to authorize service

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PSYCHIATRIC REFERRAL FOR HOME INSTRUCTION

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?_____

_____

_____

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

_____

This section to be completed by a California licensed psychiatrist: RQD: Estimated Date of Return **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**