DINWIDDIE COUNTY Public Schools

Treatment Plan for Homebound Instruction

The following is completed and <u>accompanied with a Homebound Referral</u> for:

Student's Name _____ School _____

Physician Treatment Plan:

Psychiatrist/Clinical Psychologist Name _____ Contact Number _____

Treatment Modality: _____

Frequency of Visits: _____

Estimated Date to Return to School: _____

Medications: _____

Name of Therapist Providing Behavioral Intervention: _____

If no therapist, please provide explanation: _____

Therapist Treatment Plan:

_____

_____

_____

_____

Therapist's Name _____ Discipline _____

Diagnosis: _____

Estimated Date to Return to School: _____

Treatment Modality: _____

Frequency of Therapy: _____

Treatment Goal: _____

_____

_____

_____

_____

School Contact Person: _____

<u>There is a mandatory review in nine weeks.</u> Please attach all pertinent information.

Fax completed form to: Ms. Pamela Fields. – Fax #: (804) 469-4499.

Note: This form must be updated every nine weeks noting progress toward goal of student returning to school.