Dinwiddie County Public Schools Exceptional Education Department

Treatment Plan for Homebound Instruction

The following is completed and accompanied with a Homebound Referral 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: _____

There is a mandatory review in nine weeks. Please attach all pertinent information.

Fax completed form to: Dr. Pamela Joyner. – Fax #: (804) 469-4499.

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