Hospital Homebound Program

Learning Support Services
604-532-0188

604-532-8954 (fax)

Confidential Medical Information

This form must be completed by referring Physician or Psychiatrist who is <u>currently</u> treating patient for this illness

NAME OF PATIENT: ____

NAME OF DOCTOR: ____

LENGTH OF TIME DOCTOR HAS TREATED PATIENT: _____________________

DOCTOR'S PHONE NUMBER: ____

NATURE OF ILLNESS: (This service is NOT provided while illness is contagious)

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PLEASE PROVIDE ADDITIONAL INFORMATION TO EXPLAIN AND SUPPORT THIS REQUEST WHEN IT INVOLVES EMOTIONAL/PSYCHIATRIC ISSUES.
(The family will be required to provide a release of information form.)

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EXPECTED LENGTH OF ABSENCE FROM SCHOOL:

_____ 2-4 weeks _____ 8-12 weeks

_____ 5-7 weeks _____ unknown*

*If unknown, an updated doctor's note will be required after 8 weeks. If services are still needed after the 8 week mark, the student's illness will be considered a chronic condition and he or she will be transitioned to Distance Learning.

Doctor's Signature: ______________________________ Date: ______________________