RESET FORM

Office of Home and Hospital Teaching

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PSYCHIATRIST/ PSYCHOLOGIST VERIFICATION: Emotional Conditions

Parent/Guardian:
This form **must be completed** by a **licensed psychiatrist, licensed psychologist, or licensed psychiatric mental health nurse practitioner**.Services may be denied if the referring psychiatrist, licensed psychologist, or licensed psychiatric mental health nurse practitioner cannot be reached within **three school days** of the initial attempt to make contact. Your signature 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. Home and Hospital Teaching (HHT) is a **temporary** support for a student experiencing an emotional condition. It is **not daily classroom instruction**. Approved students may receive 6 hours of support **per week** compared to 30+ hours of instruction provided in school. **Prince George's County Public Schools does not offer online or virtual school in lieu of regular school attendance.**

Parent Signature: _____ Date: _____

Student Information:

Student Name: _____ Date of Birth: _____

Grade: _____ PGCPS ID#: _____ School: _____

Medical Information for Home & Hospital Teaching(HHT) Determination
(Student's Medical Provider Completes)

1. **Medical diagnosis** (DSM-5-TR or ICD-10 code(s)) and the **reason student cannot attend school for 20 or more school days with this diagnosis. If necessary, attach additional documentation** to aid the district in determining why accommodations at school are not appropriate for the student. **This form is valid for 60 calendar days from the date of the physician's signature.**

2. Based on this diagnosis and reason above, the student is (**Check one**):
   - ☐ Unable to attend school for more than **20 consecutive school days.**
   - ☐ May attend school intermittently as emotional condition permits.

3. Select any school supports that would allow the student to transition back to school gradually. (**Check all that apply**):
   - ☐ Adjusted Academic Workload (e.g., amount of work, time spent working, level of difficulty).
   - ☐ Accommodations (e.g., extended time, reduced distractions, brain breaks, etc.)
   - ☐ Adjusted School Schedule/Modified Day (e.g., school day, time in class, class schedule)
   - ☐ School Counseling or Mental Health Support at School (e.g., check-in/out, counselor check-ins, flash pass)

4. I am the provider who provides medication management for the above-named student. ☐ **NO** ☐**YES**

5. I am the provider who provides mental health/behavioral therapy for the student named above. ☐ **NO** ☐**YES**

6. Date of first appointment with student _____. Date of most recent appointment _____.

7. Is the student currently taking medication for his/her mental health? ☐ **NO** ☐ **YES**

8. Provide the names of the medication and dosage. _____

9. Has treatment of this emotional condition required hospitalization or time in a residential facility? ☐ **NO** ☐ **YES**

10. If yes, provide names of facilities and dates of stays. _____

11. A treatment plan with therapy goals must be submitted with this form. I have provided a copy of the treatment plan and therapy goals for this student to be submitted with this form. ☐ **NO** ☐ **YES**

12. **Proposed HHT begin date** (This date must be a date after the medical provider's signature below): _____

13. **Proposed HHT end date. NOT to exceed 12 weeks**: _____.
    NOTE: HHT is not a year-long service. Students are expected to transition back to school.

Medical Provider's Signature: _____ **Date:** _____

Provider's Name (Print): _____ **License Number:** _____

Select One: ◯ Licensed Psychiatrist ◯ Licensed Psychologist ◯ Licensed Psychiatric Mental Health Nurse Practitioner

Provider's Email: _____ **Provider's Contact Number:** _____

This form may ONLY be signed by a licensed psychiatrist, licensed psychologist, or licensed psychiatric mental health nurse practitioner.