WCPS | Washington County Public Schools

10435 Downsville Road
Hagerstown MD 21740
301-766-2955
Department Of Student Services

Home/Hospital Teaching Treatment Plan for *Emotional* Referral

This form must be completed by treating licensed psychologist/psychiatrist only.
Please respond to each question.

Name of Student: _____ Date of Birth: _____

School: _____

1. Diagnosis: _____

2. Is the student seen on regularly scheduled visits to your office? □ Yes □ No
   Frequency of Visits: _____ Date of Last Visit: _____

3. Is the student currently in therapy? □ Yes □ No
   Therapist's Name: _____ Phone: _____
   Frequency of Visits: _____ Date of Last Visit: _____

4. Is the student on medication? □ Yes □ No
   Medication(s): _____
   How will the medication(s) affect instructional performance? _____
   _____

5. Describe your treatment plan and how it addresses the student's emotional condition. Please feel free to attach additional information as needed. _____
   _____
   _____

6. Is Home & Hospital Teaching (HHT) the preferred academic placement? If so, why? _____
   _____
   _____

7. Are there any modifications or accommodations that could be made by the student's school that would allow the student to return to/remain in school rather than receive HHT? _____
   _____
   _____

8. What is the plan to transition the student back to school? _____
   _____
   _____

9. What is the anticipated length of time HHT will be necessary? (**60 days maximum for full time/annual re-verification for intermittent**)

   Start date: _____ (Must match start date on HHT Application) End date: _____
   (cannot be earlier than the physician's signature date)

Name of licensed psychologist/psychiatrist providing treatment (please print):_____

Phone: _____ Fax: _____

→ Signature of □ Psychiatrist □ Licensed Psychologist _____ Date: _____
□ Nurse Practitioner **Original signature required, stamped signature is not acceptable**

→ Reviewed & recommended by _____, Pupil Personnel Worker Date: _____