**The George Washington University Student Health Center**

University Student Center, Ground Floor 800 21st St NW, Washington, DC 20052\*

Phone: 202-994-6827 Fax: 202-994-2622

**Dear Doctor,**

**Please fill out the form below so this student may continue treatment at GW SHC. Once you have completed the form, please mail or fax back to our office.**

***Please include a release of medical information form with patient contact information and a copy of your chart notes (at minimum - first & last notes.) Also, please include information regarding patient’s last prescription.***

**DOCUMENTATION OF PREVIOUS ADHD TREATMENT**

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_\_/ \_\_\_\_\_\_\_

Physician/Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: ( \_\_\_\_\_)\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_ Fax: ( \_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

**Have you ever diagnosed and treated this patient with ADHD in the past?** Yes No

If yes, what are the approximate dates you have treated this patient for ADHD? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Which type? \_\_ADHD, inattentive-predominant \_\_ADHD, combined type \_\_ADHD, hyperactive-predominant **How would you describe your practice?**

 \_\_Pediatrician \_\_Family Practice \_\_Psychiatrist \_\_ Psychologist \_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How was the diagnosis made?** *(Check all that apply)* \_\_Psychoeducational testing \_\_Clinical interview & observation \_\_Via validated checklists by patient \_\_Via checklists by parents \_\_via checklists by teachers

 \_\_Referred to Psychiatrist \_\_Referral to Psychologist \_\_Other …………………………………….

**Please list current medication/s prescribed for this patient for ADHD. Continue on back if needed.**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of medication & range of dose(s)  | Pt’s age or dates at time of prescription  | Effectiveness with ADHD  | Pt’s side effects while on medication  |
|  |  | Very Somewhat Not effective  | ↓Appetite insomnia irritability other  |
|  |  | Very Somewhat Not effective  | ↓Appetite insomnia irritability other  |
|  |  | Very Somewhat Not effective  | ↓Appetite insomnia irritability other  |

**Please list previous medication/s prescribed for this patient in the past for ADHD. Continue on back if needed.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of medication & range of dose(s)  | Pt’s age or dates at time of prescription  | Effectiveness with ADHD  | Pt’s side effects while on medication  | Why did Pt stop Medication?  |
|  |  | Very Somewhat Not effective  | ↓Appetite insomnia irritability other  |  |
|  |  | Very Somewhat Not effective  | ↓Appetite insomnia irritability other  |  |
|  |  | Very Somewhat Not effective  | ↓Appetite insomnia irritability other  |  |
|  |  | Very Somewhat Not effective  | ↓Appetite insomnia irritability other  |  |
|  |  | Very Somewhat Not effective  | ↓Appetite insomnia irritability other  |  |

**Please state if this patient was diagnosed or treated with any other emotional or behavioral health conditions.**

\_\_Alcohol or Drug Use Problems \_\_Oppositional defiant disorder \_\_Depression \_\_Anxiety disorder \_\_Bipolar disorder \_\_Chronic disorder \_\_Learning disability \_\_Other

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**Please list other psychiatric medication(s) prescribed for this patient. Continue on back if needed.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of medication & range of dose(s)  | Pt’s age or dates at time of prescription  | Effectiveness of medication  | Pt’s side effects while on medication  | Why did Pt stop Medication?  |
|  |  | Very Somewhat Not effective  |  |  |
|  |  | Very Somewhat Not effective  |  |  |
|  |  | Very Somewhat Not effective  |  |  |
|  |  | Very Somewhat Not effective  |  |  |

**Please list other medical conditions or medications for this patient:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any concerns about this patient misusing stimulants, other medications or substances? \_\_\_\_No \_\_\_\_Yes**

**If yes, please explain:**

Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**Did you remember?**

Patient contact information

 Release of information form for psychiatric records

 A copy of your chart (at minimum, first and last note, including information regarding the last prescription written)