The George Washington University Student Health Center

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

Phone: 202-994-5300 Fax: 202-994-2622

Dear Doctor,

Please fill out the form below so this student may continue treatment at GWU 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 _____

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)

Authorization To Release and/or Receive Copies of Psychiatry Records
The George Washington University Student Health Center

University Student Center, Ground Floor
800 21st Street, NW | Washington, DC 20052
P: 202-994-5300 | F: 202-994-2622
Healthcenter.gwu.edu

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

Submit this request to shs@gwu.edu
Submit payment at https://my.gwu.edu/mod/cse Reference ID#_____

- Psychiatric Records: $15
- Psychiatric Records Third party request: $30

**Please allow up to 14 business days to complete record requests for psychiatric records

Student/Patient Information
Name: _____
Date of Birth: _____(MM/DD/YYYY)
GWID: _____

I request and authorize the George Washington University Student Health Center ☐ to provide ☐ to receive copies of my psychiatric records, as outlined below, to and/or from the following entity/individual:

Name of Entity/Individual: _____
Address: _____
Phone: _____
Email: _____
Fax: _____

Scope of Authorization to Release Psychiatric Records[1]:
☐All Psychiatric Records
☐Psychiatric Records related to following visits: _____

PLEASE NOTE: if any record outlined above contains information regarding the student/patient's HIV/AID status, drug/alcohol abuse, or sexually transmitted disease, the student/patient is hereby authorizing disclosure of this information.

Purpose of Disclosure:
☐ To the Patient/Student ☐ For transition/continuity of health ☐ For payment/Insurance purposes
☐ For legal purposes ☐ Other: _____

Mode of Delivery (Select One):
☐Hold for Pickup ☐Email: _____ ☐Fax: _____
☐Mail to: _____

By signing below, I acknowledge and understand that:

- I am authorizing the University to release and/or receive a copy of my psychiatric records as outlined above.
- After the University Student Health Center discloses these records, the copies may no longer be protected by federal or local privacy laws.
- I have a right to inspect and receive a copy of the disclosed material.
- This authorization will expire upon fulfillment of this disclosure or earlier upon receipt of my written revocation to Immunreq@gwu.edu. I understand that revocation will not apply to information that has already been released in response to this authorization.
- This form is voluntary and I have the right to refuse to sign it. My treatment, payment, or eligibility of benefits will not be conditioned upon my authorization of this disclosure.

I represent and warrant that I have the authority to sign this document and authorize the disclosure and/or receipt of these records and that there are no claims or orders pending or in effect that would limit or restrict my ability to authorize this disclosure.[2]

Printed Name: _____
Signature: _____
Date: _____

[1]Signers other than the patient/student must present legal documentation that authorizes them to act as a Personal Representative.