The George Washington University Colonial Health Center

Marvin 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 GWU CHC. 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)

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON DC

Colonial Health Center

AUTHORIZATION FOR RELEASE OF PSYCHIATRIC RECORDS

Print Name:

Last/Maiden: _____ First: _____ MI: _____

Date of Birth: _____ GWID#: _____ Phone Number: _____

First Semester Term: _____ Last Semester Term: _____

Please check all that apply: ☐ Current Student ☐ Former Student

I, the undersigned, request and authorize:

Colonial Health Center
The George Washington University
Marvin Center, Ground Floor
800 21st St NW, Washington, DC 20052
Phone: (202)994-6827 | Fax: (202)994-2622

☐ **To Provide to:**
*Fees apply *

☐ **To Receive From:**
Fees do not apply

Name: _____
Address: _____
_____
Phone: _____

The following information:

☐ **Partial Psychiatric Records** *$5.00 Limited to visit on (Specify Date): _____
☐ **All Psychiatric Records *** $15.00 (Visits at Student Health Service)
☐ **All Psychiatric Records** *$30.00 (Visits at Student Health Service, **Prior to Fall 2000/3rd party request**)
☐ **Other:** _____

Please allow **7-10 business days** for this request. Records **will not** be sent without payment.

☐ Mail

☐ Hold for Pick Up on _____

Credit Card Payments: **(Discover and American Express Cards Not Accepted)**
Card # __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date _____ /_____

Zip Code of Billing Address _____

I authorize and request for my sole benefit the release of the above psychiatric information which is a part of my file in the Colonial Health Center at The George Washington University. In addition, I hereby authorize The George Washington University to discuss the psychiatric records identified above with the person(s) identified above. I understand I have the right to refuse to sign this form, and that I may revoke my authorization in writing at anytime (except to the extent that the information has already been released). This authorization will expire on the following date or event: If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed. I hereby completely and fully release and discharge The George Washington University of any and all liability for furnishing the information requested. Description of "Other" information to be incorporated into my "Authorization for Release of Psychiatric Records": All health care information, reports and/ or records concerning my medical history, status, admittance, condition, diagnosis, testing, prognosis, treatment, billing information and identity of healthcare providers, whether past, present or future and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected psychiatric information with the person or entity who has possession of the protected psychiatric information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected psychiatric information to the persons named in this authorization.

Patient Signature _____ **Date** _____

FOR OFFICE USE ONLY

☐ Mailed ☐ Picked up CHC Initials:_____ Date:_____ Payment Received: Initials_____ Date:_____