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

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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)

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**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:**  **To Receive From:** \*Fees apply \* 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 Credit Card Payments: **(Discover and American Express Cards Not Accepted)**

Card # \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

* Hold for Pick Up on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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:\_\_\_\_\_\_

01/15