ADHD INSTRUCTION SHEET

Included in this ADHD packet are the forms that need to be filled out in order for us to determine if we can provide your medication.

1) (Request Form)
   To be completed by student and signed

2) (History Form)
   To be filled out completely by student and signed

3) (ADHD Treatment Documentation)
   Top portion to be filled out by student ONLY. The rest needs to be completed by your previous provider who prescribed your ADHD medication(s), and/or diagnosed you. (This form will be faxed over to your last provider to be completed)

4) (Authorization for Request of Confidential Information) / Medical Records Request
   - Must be filled out by student and signed and dated at the bottom. Leave the witness line blank
   - (This form allows us to receive information from your previous prescriber(s) that you listed on the "Treatment Documentation" form) If you have more than one provider, please request an additional form.

RETURN COMPLETED ADHD FORMS to:
CAPS Front desk 3rd floor
ATTN: Cynthia Gomez - Medical Assistant
Phone: 520-621-2379
Fax: 520-621-0263

When all forms are received and completed you will be contacted by Cynthia, CAPS Medical Assistant.
ADHD Treatment Services (Request form)
TO BE COMPLETED BY STUDENT

Student Name: ___________________________ DOB: ___________ Cell: _______________
Address: ___________________________________________ Student ID: _______________

Please read and review the CAPS ADHD informational pamphlet before completing this form. Whenever possible... determine if your current provider is able to continue medication management while you are attending the University of Arizona.

If you have been diagnosed with ADHD and medications have been prescribed or recommended:

- Complete ADHD History Form
- Sign authorizations for your provider to send your ADHD treatment history to CAPS.
  - Authorization for Request of Confidential Health Information
  - Permission for Telephone Consultation (optional)
- Complete the top portion of the ADHD Treatment Documentation to be sent to provider.
- Request your provider to send treatment documentation, OR request that CAPS mail/fax the form for you.

The Medical Assistant will contact you once we have received your records to schedule a psychiatric evaluation and medication management appointment with a CAPS Psychiatry provider.

No previous diagnosis of ADHD:

Please complete the ADHD History Form with the symptoms you have that may be related to ADHD. Attach with this Treatment Request page and submit to the CAPS Psychiatry Medical Assistant. Your request will be reviewed and you’ll be contacted for further assessment as indicated.

Student Signature ___________________________________________ Date of request __________

Contact: CAPS Psychiatry Medical Assistant
Phone: 520-621-2379 Fax: 520-621-0263
ADHD History Form (for Student)

Please complete this form about your ADHD history, OR the symptoms you have that may be related to ADHD

DATE: __________________

Name: ___________________ DOB: ________ Student ID: ________________

Local Address: ___________________________ Cell: ________________

1. Please list the attention symptoms that are most troublesome for you:
   a. ______________________
   b. ______________________
   c. ______________________

2. If you have been diagnosed with ADHD what professional made the diagnosis?

3. Did you have any psychological or cognitive testing to confirm or support the diagnosis?

4. Please list your current and past ADHD medications:

<table>
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<tr>
<th>ADHD MEDICATION HISTORY</th>
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<tr>
<td>CURRENT MEDICATIONS</td>
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<tr>
<td>Name of medication</td>
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<th>PAST MEDICATIONS</th>
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5. Please list any other mental health issues or diagnoses:

6. Please briefly describe any academic difficulties you are having, or have experienced in the past:

7. Please describe your use of alcohol or other substances:

8. Driving record, (moving violations, DUI, accidents, license suspension, etc.):

9. Please use the back of this form to add any information that you feel is relevant for consideration.

Student Signature: ___________________________
ADHD TREATMENT DOCUMENTATION (for Provider)

*TO BE COMPLETED BY STUDENT

*Student Name: ___________________________ *Date of birth: _______ *Student ID: ________________

*Name of previous Physician/Provider: __________________________________________________________

*Provider's Full Address: ______________________________________________________________________

*Office Phone: ____________________________ *Office fax: __________________________________________

Dear Provider, TO BE COMPLETED BY PREVIOUS PHYSICIAN/PROVIDER

Please see attached signed consent for release of this information along with records. Patient has requested ADHD treatment services by the CAPS Psychiatry Team while in residence. If you would prefer to continue medication management please indicate below.

Kindly complete the questions below in order to document diagnosis and any medications prescribed. Please feel free to contact the CAPS Psychiatry Team with any questions or concerns.

☐ I prefer to continue medication management with this student.

1) Have you diagnosed or treated this patient with ADHD? YES _____ NO ______

If yes, please indicate the approximate dates: FROM: ___________ TO: ___________

2) DIAGNOSIS:

____ ADHD, Combined ____ ADHD, Inattentive ____ ADHD Hyperactive ____ other

3) HOW WAS DIAGNOSIS MADE: _____ Clinical Impression _____ ADHD Screening Tools (indicate type)

_____ Psychological/cognitive testing (please forward results if available) _____ Other testing (please specify)

4) OTHER RELEVANT medical or mental health conditions:

5) MEDICATIONS: Please list current ADHD medication/doses and any in the past:

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<tr>
<td>Name of medication</td>
<td>Dose</td>
<td>How long?</td>
<td>Effectiveness</td>
<td>Side effects</td>
<td>Comments</td>
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<tr>
<th>Past Medications</th>
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ADHD MEDICATION HISTORY

Provider Signature

Please fax or mail records to:
COUNSELING AND PSYCH SERVICES
University of Arizona, Campus Health Service, P.O. Box 210095
Tucson, AZ 85721-0095

Printed name Phone: 520-621-2379
Fax: 520-626-0263
Attn: Psychiatry Medical Assistant

ADHD Treatment Documentation - Provider  Rev 5/30/19
I authorize the office designated below to release my health information to Counseling & Psych Services, The University of Arizona from (dates of service):  

FROM: Organization / Individual:  
Address:  
City: State: Zip:  
Phone: Fax:  

Please fax or mail records to: COUNSELING & PSYCH SERVICES  
The University of Arizona / Campus Health Service  
P.O. Box 210095  
Tucson, AZ 85721-0095  
Phone: 520-621-2379 FAX: 520-621-0263  

PURPOSE FOR RELEASE:  

□ Continuity of Care  
□ ADHD Testing Results  
□ Assessment / Evaluation  
□ Attendance  
□ Behavioral Health, Psych  
□ Lab Reports  
□ Other  
□ Letter/Correspondence  
□ Psychiatrist Treatment Summary  
□ Psychological Testing  
□ Telephone Communication  
□ Treatment Summary/Content  

I hereby release the Campus Health Service and the University of Arizona from any liability that may arise as a result of this authorization. I certify that I gave this consent freely and voluntarily, and understand that my right to receive services is not contingent upon my giving this consent. I may revoke this consent by notifying the organization/individual above in writing at any time, except to the extent that they acted on this consent before I revoked it. My consent automatically expires after one year unless an alternate date is specified.  

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above. I understand that the individual or agency who receives the record pertaining to this consent may NOT re-disclose the record to any individual or agency without a separate written consent from me, unless such recipient is a provider who makes a disclosure permitted by law.  

I understand that if I agree to sign this authorization, I must be offered a signed copy of the form.

Student Signature (Parent/Legal Guardian if minor)  
Print Name  
Date  

Description of Authority to sign if legal representative:  

Student I.D. Number: Date of Birth:  

Witness Signature  
Print Witness Name  
Date  

CAPS Psych Dept. 3/18  

COUNSELING & PSYCH SERVICES  
The University of Arizona / Campus Health Service  
P.O. Box 210095 Tucson, AZ 85721-0095  
Phone: 520-621-2379 FAX: 520-621-0263  
www.health.arizona.edu  
Fully accredited by the Accreditation Association for Ambulatory Health Care (AAAHC), Inc.