THE UNIVERSITY OF ARIZONA
CAMPUS HEALTH
Counseling & Psych Service

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 ONLY is to be filled out by student. 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 - R.O.I. / Medical Records Request form**
   - Must be filled out by student and signed and dated at the bottom. Leave the witness line blank
   - *(This form will also be faxed, and 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 ALL 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.

THE UNIVERSITY OF ARIZONA
CAMPUS HEALTH
Counseling & Psych Service
1224 E. Lowell Street, Bldg. 95 3rd floor
Tucson, Arizona 85721-0095
Tel: 520-621-2379
Fax: 520-621-0263

THE UNIVERSITY OF ARIZONA
CAMPUS HEALTH
Counseling & Psych Service

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 (signed electronically) **Date of request**

Contact: CAPS Psychiatry Medical Assistant
Phone: 520-621-2379 **Fax: 520-621-0263**

THE UNIVERSITY OF ARIZONA
CAMPUS HEALTH
Counseling & Psych Service

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:

ADHD MEDICATION HISTORY					
CURRENT MEDICATIONS					
Name of medication	Dose	How long?	Effectiveness	Side effects	Comments
PAST MEDICATIONS					

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 (signed electronically): _____

THE UNIVERSITY OF ARIZONA
CAMPUS HEALTH
Counseling & Psych Service

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. ****SECTION BELOW 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 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:

ADHD MEDICATION HISTORY					
CURRENT MEDICATIONS					
Name of medication	Dose	How long?	Effectiveness	Side effects	Comments
PAST MEDICATIONS					

Provider Signature (signed electronically) **Printed Name** **Date**

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

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

AUTHORIZATION FOR REQUEST OF CONFIDENTIAL HEALTH INFORMATION (Psychiatry)

THE UNIVERSITY OF ARIZONA
CAMPUS HEALTH
Counseling & Psych Services

I authorize the office designated below to release my health information to Counseling & Psych Services, The University of Arizona
from (dates of service): _____ to _____
Date you started seeing provider *Date / Present*

FROM: *Information on Provider*
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***

(Initials required after each box checked)

PURPOSE FOR RELEASE: *Initials*		**INFORMATION AUTHORIZED** *Initials*			*Initials*
☐ Continuity of Care	_____	☐ Behavioral Health, Psych	_____	☐ Psychiatrist Treatment Summary	_____
☐ ADHD Testing Results	_____	☐ Lab Reports	_____	☐ Psychological Testing	_____
☐ Assessment / Evaluation	_____	☐ Other	_____	☐ Telephone Communication	_____
☐ Attendance		☐ Letter/Correspondence	_____	☐ 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 Immuno-deficiency 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.
Be sure you sign here

X _____ _____ X _____
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
Someone in CAPS needs to witness your signature.

LABEL

CAPS Psych 04/21 cg