



DOCUMENTATION OF PREVIOUS ADHD TREATMENT

Providers, please fill out the form below so that this student may continue treatment at AU SHC. **Please include a copy of chart notes and any information regarding recent prescriptions.** Please email fax or mail the completed form and accompanying notes back to our office.

Students Name: _____ Date of Birth _____

Providers Name: _____ Specialty _____

Name of Practice: _____

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? _____ Predominate inattention _____ combined type _____ Predominate hyperactivity

How would you describe your practice? ___ Pediatrician ___ Family Practice ___ Psychiatry
___ Psychologist Other _____

How was this diagnosis made? (Check all that apply)

- ___ Psycho-educational testing
- ___ Validated checklists via parents and/or teachers
- ___ Clinical Interview and observation
- ___ Referral to Psychiatrist
- ___ Validated checklists by patient
- ___ Referral to Psychologists
- ___ Other _____

Please list any medication this patient is currently taking:

Please state if this patient was diagnosed with or treated for any other behavioral health condition:

Please list any other medical conditions for this patient:

Do you have any concerns about this patient misusing stimulants or other substances? ___NO ___YES

If yes, please explain:

Name of Provider: _____

Signature _____ **Date** _____

****This form MUST accompany copy of notes and prescription history to be considered complete**