

PLEASE RETURN BY FAX OR MAIL TO:
SLC HEALTH & WELLNESS CENTER
1 MEAD WAY BRONXVILLE, NY 10708
914-395-2350 (PHONE) 914-395-2640(FAX)

STUDENTSECTION:

_____, AUTHORIZES THE COMPLETION AND TRANSMISSION OF
STUDENT NAME (PLEASE PRINT)
THE FOLLOWING CLINICAL INFORMATION TO SARAH LAWRENCE COLLEGE HEALTH SERVICES:

STUDENT SIGNATURE DATE

PROVIDER SECTION:

STUDENT NAME: _____ D.O.B.: _____/_____/_____

DIAGNOSIS: (If ADHD, please provide testing data if completed): _____

LENGTH OF CURRENT TREATMENT:

PRIOR TREATMENT HISTORY (PLEASE PROVIDE CLINICAL NARRATIVE/SUMMARY-)

CURRENT CLINICAL IMPRESSIONS:

CURRENT MEDICATION AND DOSAGES:

PREVIOUS MEDICATIONS AND DOSAGES:

IS STUDENT **CURRENTLY BEING PRESCRIBED PSYCHIATRIC MEDICATION** THAT YOU WOULD LIKE
CONTINUED BY THE SLC HEALTH & WELLNESS CENTER PSYCHIATRIST? _____ YES _____ NO

RECOMMENDATIONS FOR MEDICATION TREATMENT (IF REQUESTING ADHD MEDICATIONS PROVIDE
EITHER NEUROPSYCH TESTING **OR** SIGNIFICANT CLINICAL NARRATIVE THAT SUBSTANTIATES DECISION
MAKING AROUND DIAGNOSIS-IF POSSIBLE ATTACH MOST RECENT CLINICAL NOTE)

ANY KNOWN CHEMICAL DEPENDENCY ISSUES:

(Cont. on next page)

ARE YOU REQUESTING AN EVALUATION BY THE SLC HEALTH & WELLNESS CENTER PSYCHIATRIST
TO BEGIN PSYCHIATRIC MEDICATION? ____ YES ____ NO

IS STUDENT **CURRENTLY ENGAGED IN PSYCHOTHERAPY**? ____ YES ____ NO

IF YES, INDICATE THE NAME AND CONTACT INFORMATION OF CURRENT THERAPIST

**PLEASE NOTE: STUDENTS MUST BE ENGAGED IN PSYCHOTHERAPY IN ORDER TO BE PRESCRIBED PSYCHIATRIC
MEDICATION (OTHER THAN ADHD MEDICATION) BY THE SLC HEALTH & WELLNESS CENTER PSYCHIATRIST.**

SIGNATURE

LICENSE #

DATE

CLINICIAN NAME:

ADDRESS:

PHONE/FAX: