

Sarah Lawrence College Health & Wellness Center
DOCUMENTATION OF PREVIOUS ADHD TREATMENT

This form must be completed by your current treating provider for review prior to setting up care at Sarah Lawrence College Health and Wellness Center-for ADHD medication refills. SLC Health and Wellness services adheres to best practices with regard to treatment of ADHD through medication refills. For students with a complex ADHD and psychiatric medication regimen we refer to off campus providers. Student's must have a documented 6 month stable treatment plan history to be considered for in-house ADHD medication refills.

Please note that SLC Health and Wellness does NOT refill stimulant medications prior to the completion of our assessment process. This form is separate from registering with ACCESS & Disability Services.

In addition to this form please include a copy of chart notes, information regarding recent prescriptions, and neuropsychological testing if previously completed. Please email, fax or mail the completed form and accompanying notes back to our office.

healthservices@sarahlawrence.edu or Fax: 914-395-2640 or Mail to: 1 Mead Way, Bronxville, NY 10708

Students Name: _____ Date of Birth _____

Providers Name: _____

Specialty: _____

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? _____

Date of last visit? _____

If No-please have the student contact the Health and Wellness Center. SLC Health and Wellness requires a thorough evaluation for ADHD and further referrals may be required.

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)

- _____ Neuropsychological testing
- _____ Clinical Interview and observation over time
- _____ Validated checklists by patient
- _____ Validated checklists via parents and/or teachers
- _____ Referral to Psychiatrist
- _____ 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 note that when co-occurring issues are being treated with additional psychotropic medications the student will be referred to an off-campus provider for more comprehensive care.*

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: _____

Name of Practice: _____

Address: _____

Telephone: _____ Fax: _____

Signature _____

Date _____

Please Note:

*****This form MUST accompany copy of notes and prescription history to be considered for ADHD medication refills on campus. Additionally neuropsychological testing should be submitted if completed. When neuropsychological testing is not available significant documentation and history must be provided to support diagnosis*****