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)

STUDENT SECTION:

_____, 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 SUBSTIANTES DECISION MAKING AROUND DIAGNOSIS-IF POSSIBLE ATTACH MOST RECENT CLINICAL NOTE):*

ANY KNOWN CHEMICAL DEPENDENCY ISSUES:

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: