ADHD INSTRUCTION SHEET

PLEASE READ THIS PAGE FOR INSTRUCTIONS
((Reminder: All you need to do is fill out and return all forms to Cynthia, who will take care of the rest))

Included in this ADHD packet are the forms that need to be filled out 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. (I will fax this form 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 R.O.I form.

REMINDER: RETURN ALL PAGES TO CAPS or...
FAX to... 520-621-0263
ATTN: Cynthia Gomez - Medical Assistant
   Phone: 520-626-7293

When we have received your past records, I will contact you through your patientlink to schedule your appointment.
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 ___________________________ Date of request __________

Contact: CAPS Psychiatry Medical Assistant
Phone: 520-626-7293 Fax: 520-621-0263
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:

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Dose</th>
<th>How long?</th>
<th>Effectiveness</th>
<th>Side effects</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

| 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: __________________________

DATE: ___________
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:

<table>
<thead>
<tr>
<th>CURRENT MEDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of medication</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAST MEDICATIONS</th>
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Provider Signature  
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: 520-626-7293  
Fax: 520-621-0263  
Attn: Cynthia - Medical Assistant

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AUTHORIZATION FOR REQUEST OF CONFIDENTIAL HEALTH INFORMATION
(Psychiatry)

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: 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: 520-626-7293 FAX: 520-621-0263

(Please check all applicable boxes)
PURPOSE FOR RELEASE: Initials INFORMATION AUTHORIZED: Initials
☐ Continuity of Care __________________________☐ Behavioral Health, Psych __________________________
☐ ADHD Testing Results __________________________☐ Lab Reports __________________________
☐ Assessment / Evaluation __________________________☐ Other __________________________
☐ Attendance __________________________☐ Letter/Correspondence __________________________

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 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.

CAPS Psych 04/21 cg