THE UNIVERSITY OF ARIZONA
CAMPUS HEALTH
Counseling & Psych Service

ADHD INSTRUCTION SHEET

PLEASE READ THIS PAGE FOR INSTRUCTIONS

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 form.*** ((**Reminder: All you need to do is fill out the forms, return to me, and I will take care of the rest**)).

RETURN ALL PAGES TO CAPS or…
FAX to… 520-621-0263
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.

THE UNIVERSITY OF ARIZONA
CAMPUS HEALTH
Counseling & Psych Service
1224 E. Lowell Street, Bldg. 95 3rd floor
Tucson, Arizona 85721-0095
Tel: 520-626-7293
Fax: 520-621-0263

THE UNIVERSITY OF ARIZONA
CAMPUS HEALTH
Counseling & Psych Service

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**

THE UNIVERSITY OF ARIZONA
CAMPUS HEALTH
Counseling & Psych Service

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:

ADHD MEDICATION HISTORY					
CURRENT MEDICATIONS					
Name of medication	Dose	How long?	Effectiveness	Side effects	Comments
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: _____

THE UNIVERSITY OF ARIZONA
CAMPUS HEALTH
Counseling & Psych Service

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:

ADHD MEDICATION HISTORY					
CURRENT MEDICATIONS					
Name of medication	Dose	How long?	Effectiveness	Side effects	Comments
PAST MEDICATIONS					

_____ _____ _____
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

CAPS AUTHORIZATION FOR REQUEST OF CONFIDENTIAL HEALTH INFORMATION

CAMPUS HEALTH
Psychiatry:
Phone: (520) 626-7293
Fax: (520) 621-0263

Patient Name: _____ Date of Birth: _____ Phone #: _____
(Please Print) *Last and First*

I authorize Campus Health Service/CAPS to: ☐ Release ☑ Request ☑ Exchange information with:

☐ Dean of Students ☐ Housing & Residential Life ☐ Palo Verde Behavioral Health
☐ Banner Crisis Response Center ☑ Other (Please specify below):

Name & contact information of last provider... (phone/fax are pertinent)

Name: _____
Address: _____
_____
Phone: _____
Email: _____
FAX: _____

I am releasing this information for the following purpose(s):

X Continued Care _____ Insurance Claim _____ At the Request of the Individual
_____ Legal _____ Other (Please specify) _____

This section is for CAPS releasing records ONLY

_____ I hereby consent to the release of **ALL my CAPS** records for dates of service _____ to _____.

OR

_____ I hereby consent to the release of my **CAPS records as indicated below** for dates of service _____ to _____.

Next to asterisk or where applicable

*****$6.50 copying fee for 10 or more pages (applies to patient, not legal or insurance**

Specific records only as checked below *(initials required)*:

* _____ Clinician's Progress notes
* _____ Psychiatrist Treatment Summary
_____ Letter / Correspondence
* _____ Psychological Testing
* _____ Lab results
* _____ Treatment Summary
_____ Billing Statements
* _____ Medication List
* _____ Phone communication
* _____ ADHD Testing Results
_____ Other (Please specify) _____

Last 2 - 3 office notes ONLY please.

Expiration Date: My consent automatically expires after one year from the date of signature unless an **earlier** alternate date is specified: _____ (cannot be extended past one year from date of signature).

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired immunodeficiency 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 information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. However, redisclosure by school officials may be subject to student education records privacy laws.

I understand that I am entitled to a signed copy of this form. **Right to Refuse to Sign This Authorization-** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization-** I understand written notification is necessary to cancel this authorization by submitting my written request to: The University of Arizona, P.O. Box 210095, Tucson, AZ 85721-0095 or via fax to: (520) 621-9471. I may revoke this consent at any time except to the extent that action based on this authorization has already been taken.

I have had an opportunity to review and understand the content of this authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Sign and date here...

X _____ UA ID# _____ Date X _____
Signature/Electronic Signature of Patient or Legal Guardian

Description of Authority to Sign if Legal Representative: _____

This form must be submitted with photo identification.

CAPS F-GENADM 2/2023

Pt Label Here... office use only