



ADHD INFORMATIONAL PAMPHLET (THIS IS STUDENT'S COPY)

Attention-Deficit/Hyperactivity Disorder (ADHD) is a neurological disorder that effects executive functioning in the brain. It can cause difficulties in sustained focus and concentration. Occasional difficulty in focusing, getting organized, and completing class work and assignments is common for college students at times of increased stress, and does not necessarily indicate a person has ADHD.

There are three main types of ADHD: Hyperactive, Inattentive and Combined. In the hyperactive type, students have problems with hyperactivity, fidgeting, trouble sitting still and impulsive behaviors such as blurting out answers and being intrusive. Students with the inattentive type of ADHD have problems with concentrating, focusing and seem to get lost and have problems completing tasks. The combined type of ADHD has symptoms associated with both the hyperactive and inattentive type. The disorder is first seen in childhood before age 12.

ADHD Can Mimic Other Disorders

Executive function abilities fall on a spectrum from those with excellent organizational and focus skills to those with significant impairments. The impairments must be significant and affect at least two areas of a person's life in order to meet the criteria to be diagnosed with ADHD. Other problems, too, can cause problems that look like ADHD. For example, other learning disorders can make a student look like they have inattentiveness problems. Anxiety and depression have a significant effect on the ability to concentrate and focus. Substance use can impair one's ability to concentrate and focus. Sometimes there is more than one factor involved.

ADHD Treatment

ADHD is treated with different approaches. These include cognitive behavioral therapy and others, particularly if patients want to manage symptoms without medications. Medications are also commonly effective for treatment.

CAPS Policy

Most ADHD medications are Controlled Substances that are tightly regulated by federal and state laws. When stimulant medications are prescribed and monitored after a thorough evaluation by a qualified and licensed clinician, they often have a significant and positive impact. When they are prescribed or misused without appropriate medical oversight, stimulant medications can lead to addiction, psychosis, and other serious cardiovascular side effects. In recent years, the use of ADHD medications without prescriptions by college students has increased considerably.

CAPS recognizes ADHD as a well-supported medical/psychiatric diagnosis that has the potential to limit an individual's full capacity in different life areas, including academic performance. Most medications that are effective are controlled substances that carry substantial risks if used improperly. Therefore, a higher level of caution and diagnostic clarity is required to avoid the substantial risks involved with medication misuse and potentially serious consequences.

CONT'D - ADHD INFORMATION (for student to keep)

CAPS Psychiatry Services is often limited by the increasing demand that continues to grow every school year. We encourage students to continue their ADHD treatment with their current provider whenever possible.

To request ADHD treatment services:

1. **No previous ADHD diagnosis.**

Students who feel they have symptoms that may be related to ADHD but **HAVE NOT** been diagnosed will be referred to Dr Ishani Deo, for testing. Depending on time of year there may be a wait list. If this is the case, you will be placed on this list and/or given names of Tucson providers that also do this test - who may be able to test you sooner.

2. **Students Previously Diagnosed with ADHD**

If you **HAVE** been diagnosed with ADHD and have considered, or are currently taking medication, please consult with your current provider to figure out a plan for prescription coverage while at the UofA. If, in the event this is not possible you may request services at CAPS Psychiatry. We will send you our ADHD Forms to fill out, complete and return to CAPS. You will be contacted once we have received these forms back.

FOLLOWING THIS PAGE IS OUR ADHD INSTRUCTION SHEET AND FORMS.



THE UNIVERSITY OF ARIZONA
**CAMPUS
HEALTH**
Counseling & Psvch 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 & Psvch Service

ADHD INSTRUCTION SHEET

**PLEASE READ THIS PAGE FOR INSTRUCTIONS ON HOW
TO FILL OUT FORMS**

Pg 1 - (Request Form)

This page is to be filled out by student, signed, and dated.

Pg 2 - (History Form)

This page is also to be completed by student and signed.

Pg 3 - (ADHD Treatment Documentation)

The top portion is to be filled out by student. The bottom portion is to be completed by your previous provider who prescribed your ADHD medication, and/or diagnosed you. **(This form is faxed to your last provider)**

Pg 4 - (Authorization for Request of Confidential Information/R.O.I.)

This page must be filled out by student, signed, and dated at the bottom... AND NEEDS TO HAVE SAME PROVIDER INFORMATION AS PAGE 3. **(This form will also be faxed to your previous provider)**

*****If you have more than one provider, please request an additional R.O.I form.***

**PLEASE RETURN ALL PAGES TO CAPS MAIN OFFICE, OR THROUGH
YOUR PATIENTLINK OR BY FAX AT... 520-621-0263**

ATTN: Cynthia Gomez - Medical Assistant

Phone: 520-626-7293



THE UNIVERSITY OF ARIZONA

**CAMPUS
HEALTH**

Counseling & Psvch Service

CAPS Main office...

1224 E. Lowell Street, Bldg. 95 3rd floor

Tucson, Arizona 85721-0095

Tel: 520-626-7293

Fax: 520-621-0263



ADHD Treatment Services (Request form - Pg 1)

TO BE COMPLETED BY STUDENT

Student Name: _____ DOB: _____ Cell: _____

Address: _____ Student ID: _____

If you have been diagnosed with ADHD and medications have been prescribed or recommended, here's what you need to do...

- 1st... sign and date this form acknowledging that you have read and understood the ADHD Informational pamphlet.
- 2nd... Complete the remaining 3 pages of our ADHD Forms and return to CAPS

The Medical Assistant will contact you via your PatientLink's Secure Message once we have received these forms back along with your past medical records from your last provider.

Student Signature

Date of request



ADHD History Form (for Student – Pg 2)
TO BE COMPLETED BY 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: _____

ADHD TREATMENT DOCUMENTATION (for Provider Pg - 3)

***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 *TO BE COMPLETED BY PAST 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

Attn: Cynthia - Medical Assistant

Phone: 520-626-7293 / Fax: 520-621-0263

ADHD Treatment Doc- Provider... 04.01.2024

CAPS AUTHORIZATION FOR REQUEST OF CONFIDENTIAL HEALTH INFORMATION



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):

- 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
- Treatment Summary
- Billing Statements
- Phone communication
- ADHD Testing Results
- Other (Please specify) _____
- Lab results
- Medication List

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