DOCUMENTATION OF PREVIOUS ADHD TREATMENT

Providers, please fill out the form below so that this student may continue treatment at AU SHC. **Please include a copy of chart notes and any information regarding recent prescriptions.** Please submit the completed form and accompanying notes back to our office.

- Email: **shc@american.edu**
- Fax: **(202) 885-1222**
- Mailing address:

American University
Student Health Center
4400 Massachusetts Avenue, NW
McCabe Hall
Washington, DC

Students Name:_____Date of Birth_____

Providers Name:_____Specialty_____

Name of Practice: _____

Address: _____

Telephone:_____Fax: _____

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 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:

_____
_____
_____
_____