MARYMOUNT UNIVERSITY STUDENT HEALTH CENTER
2807 North Glebe Road ◆ Arlington, VA 22207 ◆ Phone (703) 284-1610
Fax (703) 284-3816 ◆ Email: studenthealthcenter@marymount.edu

Dear Healthcare Provider:

Our policy requires students requesting a prescription for ADD/ADHD medications to provide documentation of previous diagnosis and treatment prior to providing treatment at Marymount University's Student Health Center.

Once you have completed this form, please mail or fax it back to us with a copy of your chart notes (at minimum - first and last notes) as well as psycho-educational testing, if available.

**Students please note: You may be required to make an appointment with your provider to have this form completed.*

PATIENT INFORMATION

Last name:	First name:	Date of Birth:

PRACTICE INFORMATION

Name of Practice:		Practice Address:
Telephone:	Fax :	

How would you describe your practice?

☐ Pediatrician ☐ Family Practice ☐ Psychiatrist ☐ Psychologist ☐ Other_____

How was the diagnosis made?

☐ Psycho-educational testing ☐ Clinical interview & observation ☐ Validated checklists by patient ☐ Checklists by parents

☐ Checklists by teachers ☐ Psychiatrist referral ☐ Psychologist referral ☐ Other_____

Which type?

☐ ADHD, Inattentive-predominant ☐ ADHD, combined type ☐ ADHD, hyperactive-predominant

Please state if this patient was diagnosed or treated for any other emotional or behavioral health conditions:

☐ Oppositional defiant disorder ☐ Depression ☐ Anxiety ☐ Bipolar disorder ☐ Learning disability ☐ Other_____

Last date you treated this patient for ADD/ADHD? _____/_____/_____

LIST ALL OF THE PATIENT'S MEDICATIONS CURRENTLY PRESCRIBED BY YOU

Name of medication & dosage (print clearly)

1. _____ 2. _____

3. _____ 4. _____

The student will receive medication refills at Marymount University's Student Health Center beginning on _____/_____/_____

_____

Physician/Provider's PRINTED name & title

_____ _____

Provider Signature **Date**