

CAL STATE EAST BAY

Documentation of Previous ADHD Treatment

Dear Provider: Please fill out the form below so that this student may continue treatment at AU SHC. **Please include a copy of the patient's intake note, most recent note, and currently prescribed medications.** Please submit the completed form and accompanying notes back to our office via:

- Fax: (510) 885-3230
- Mailing address:
California State University, East Bay
Student Health and Counseling Services
Attention: Medical Records
25800 Carlos Bee Boulevard
Hayward, CA 94542
Phone: 510-885-3735

Patient's Name: _____ Date of Birth: _____

Dates you treated this patient for ADHD: _____

How was their diagnosis of ADHD made? (Check all that apply): Psycho-educational testing

Validated checklists via parents and/or teachers Referral to Psychiatrist Clinical Interview

and observation Validated checklists by patient Referral to Psychologists Other (please

specify): _____

When was their ADHD diagnosis made: _____

Which type of ADHD does this patient have: Predominant inattentive Predominant hyperactive/impulsive Combined

Please list the patient's current medications:

Please list the patient's other mental health diagnoses, if any:

Please list the patient's medical diagnoses, if any:

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Have you ever had concerns about this patient misusing stimulant medication or other substances?

NO YES

Have you ever had concerns about this patient's safety while taking stimulant medication?

NO YES

If yes, please explain:

Provider Information

Printed Name: _____

Credentials: (MD, DO, PhD, ARNP, etc): _____

License #: _____ State: _____

How would you describe your practice? Pediatric Family Practice Psychiatry Psychology

Other (please specify): _____

Practice Name: _____

Phone #: _____ Fax#: _____

Email Address: _____

Signature: _____ Date: _____

Please include a copy of the patient's intake note, most recent note, and current medications. Thank you!