Student Health Services

4400 University Drive, MS 2D3, Fairfax, Virginia 22030
Phone: 703-993-2831 · Fax: 703-993-4365 · shs.gmu.edu

Documentation of ADD/ADHD Diagnosis & Treatment

Dear Healthcare Provider:

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

Once you have completed the form, please mail or fax it back to us with a copy of your chart notes (at minimum- first and last notes).

Patient's Name: ____ Date of Birth ___/____/_____
Name of Practice: ____
Practice Address: ____
Telephone: (____) ____-_______ Fax: (____) ____-______

---

1) How would you describe your practice?

__Pediatrician __ Family Practice __ Psychiatrist __Psychologist Other _______________

2) How was the diagnosis made? (check all that apply)

__Psycho-educational testing __ Clinical interview & observation
__ Validated checklists by patient __Checklists by parents __Checklists by teachers
__ Psychiatrist referral __ Psychologist referral Other_______________________________

3) Which type? __ ADHD, inattentive-predominant _ ADHD, Combined type _ ADHD hyperactive-predominant

4) 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____

5)Last date you treated this patient for ADD/ADHD? ___/_____/_______

6) **List ALL CURRENTLY prescribed medications by you-** Name of medication & dosage (print clearly)

1.____ 2.____
3.____ 4.____

☐ The student will receive medication refills at Mason's Student Health Services beginning on Date___/___/_____

Physician/Provider's PRINTED Name & Title: ____

Provider Signature: ____ Date __/__/_____