GEORGE MASON UNIVERSITY
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: (____) ____-_____

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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 __/__/_____