

## 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](mailto: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: \_\_\_\_\_

