



4189 Westlawn  
Iowa City, IA 52242  
Phone: 319-335-8370  
Fax: 319- 335-7247

Date: \_\_\_\_\_

Dear Dr. \_\_\_\_\_,

Your patient, \_\_\_\_\_, has requested to transfer psychiatric care to the University of Iowa while they are enrolled in the University. They have reported a history of a diagnosis of ADHD and that you provide care for them.

To provide treatment for ADHD at the University of Iowa Student Health, we request that the following information be sent to our office:

1. Student Health Transfer of Care for ADHD Treatment form
2. Psychological testing records
3. Notes pertaining to ADHD diagnosis and treatment

For a timely transfer of care, this information should be faxed to:  
University of Iowa Student Health  
319-335-7247

The records will be reviewed for the purpose of scheduling once they are received. If you have any specific questions about our policies or related procedures, please feel free to contact us at 319-335-8370.

Thank you for allowing us to participate in the care of your patient.

Jeniece Nott, MD, PhD  
Erin Martin, DO  
Ellen Collins, PA-C

University of Iowa Student Health Psychiatry staff



Student Health

Fax: 319-335-7247

Current Provider Name:

Provider Contact Information:

### TRANSFER OF CARE FOR ADHD TREATMENT

The following questions are to be completed by the current treating provider. All information is confidential.

<b>Patient Name</b> <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	<b>DOB:</b>
<b>Date of first appointment:</b>	<b>Date of last appointment:</b>		

**Who made the diagnosis of ADHD and how was the diagnosis made?**

**At what age was the diagnosis of ADHD made?**

**What supporting evidence was used to make the ADHD diagnosis?**

Self-report questionnaire     Psychological Testing     Vanderbilt forms     Connors forms  
 Other \_\_\_\_\_

ADHD Medication (current and past)	Current?	Current dose	Max dose titrated	Trial length	Reason for stopping medication

**Comorbid psychiatric diagnoses:**

**Treatment for comorbid conditions:**

Signature: \_\_\_\_\_ Name/Title: \_\_\_\_\_ Date: \_\_\_\_\_

Please send this form plus the following information via fax to University of Iowa Student Health 319-335-7247:

- 1.) Notes pertaining to ADHD diagnosis
- 2.) Last three treatment/progress notes.