Student Health

4189 Westlawn
Iowa City, Iowa 52242-1100
Phone:319-335-8370
http://studenthealth.uiowa.edu

University of Iowa Student Health – Psychiatry Services

Please PRINT and provide complete information in each section.

This completed form must be scanned into EPIC

Patient Name____________________ **Birth Date**____________ **UI ID**___________ **Date**__________

Your patient has requested to transfer psychiatric care to the University of Iowa Student Health 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 last three treatment notes

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
Keith Guess, PA-C

University of Iowa Student Health Psychiatry Staff

Fax: 319-335-7247

Current Provider Name:
Phone:
Address:

TRANSFER OF CARE FOR ADHD TREATMENT

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

Patient Name *(Last,First, M.I.):*	☐ M ☐ F ☐ Other	**DOB:**
Date of first appointment:	**Date of last appointment:**	

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.