Psychiatry
University of Iowa Student Health
4189 Westlawn
Iowa City IA 52242 Phone:
319-335-8394
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 including (but not limited to) the last three treatment/progress notes**

In order 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 one of our psychiatric providers or our psychiatric nurse at 319-353-5766.

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

Paul Natvig, MD
Jeniece Nott, MD, PhD
Staff Psychiatrists
University of Iowa Student Health

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.

Patient Name *(Last,First, M.I.):*	☐ M ☐ F	**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) Psychological testing records
2) Notes pertaining to ADHD diagnosis and treatment
3) Last three treatment/progress notes