

Mount Holyoke College Health Services
Request for ADHD medication management

Student Name: _____

DOB: _____ Class year: _____

Documentation of your ADHD evaluation must be from a health care clinician(s) who is appropriately credentialed and whose scope of practice includes the diagnosis of attentional problems. This clinician must not be related to the student submitting this form. We require that the submitted documentation include:

1. A comprehensive diagnostic interview by a qualified physician, psychologist, or other provider whose scope of practice includes the diagnosis of attentional problems
 - Use of ADHD rating scales completed by the student AND third-party reporters (ie parent/guardian, teachers, school reports)
 - Preferably including psychological &/or neuro-cognitive testing
2. Evidence of symptoms before the age of 12
3. Evidence of current impairment in two or more settings
4. Assessment of possible comorbid conditions which may also cause attentional issues including learning disorders, mood disorders, anxiety disorders and substance use disorders

- I have a diagnosis of Attention Deficit Hyperactive Disorder (ADHD, or ADD)
- I have requested that a copy of my comprehensive ADHD evaluation be sent to MHC Health Services, Attn: ADHD coordinator: 50 College St.; South Hadley, MA 01075,
or by fax to 413-538-2352

Name, address &/or phone of clinician/office sending records:

- I am currently taking medication for ADHD

medication name/dose:

date of last Rx:

name of prescribing medical provider:

By signing below, I attest to the accuracy of the above information, grant permission for the clinician to share the requested information with MHC Health Services, and request to transfer my ADHD medication management to Health Services.

Student Signature: _____ Date: _____