Dear Student,

Thank you for inquiring about the Student Health Center managing your prescription. In order for us to consider your request, the following criteria should be met:

• You have a diagnosis that is appropriate for the medication
• You have a current provider and an existing prescription for the medication
• You have been on a stable dose of the medication for 6 months or more
• You do not have side effects to the medication that need monitoring
• There are no other medical or psychiatric conditions that complicate the management of this disorder

If you met the above criteria, we are requesting the following information to review:

• Information Form for Prescription Management. This attached form should be filled out by your current prescriber.

In addition, the following is required if you are requesting management for ADD/ADHD medications:

• Documentation that supports your diagnosis of ADD/ADHD such as neuropsychological testing, psychoeducational evaluation, documentation of history of impairment, and/or evaluation from multiple settings (home, school, activities, etc.). Supporting documentation is typically found in your medical records from the time of diagnosis or school/academic records.

Please submit your supporting documentation along with the Information Form for Prescription Management for review. Once a medical provider reviews your documents you will be contacted by secure message with our recommendations (either management by us or options for management in the community).

Sincerely,

Kimberly Woodruff, MD, MPH
Supervising Physician
University of San Diego Student Health Center
Dear Prescribing Provider:

Your patient, _________________________, is a student at the University of San Diego and would like a Student Health Center physician to assume the responsibility of prescribing his/her prescription for ___________________________. In cases such as this, we agree to provide prescriptions for their medication when the student meets the following criteria:

- The student has a diagnosis of that appropriate for this medication
- The student has a current provider and an existing prescription for the medication
- For ongoing long-term medication, a stable dose of the medication for 6 months or more
- An appropriate weaning plan when applicable (such as narcotics)
- She/he does not have side effects to the medication that need monitoring
- There are no other medical or psychiatric conditions that complicate the management of this disorder
- For diagnoses of ADD/ADHD, the student must provide additional documentation that supports the diagnosis (neuropsychological testing, psychoeducational evaluation, documentation of impairment, and/or evaluations from multiple settings).

Please provide the information on the following form, sign and date, and then either fax or mail this form back to us at the number or address above.

Thank you,

Dr. Kimberly Woodruff, MD, MPH
Supervising Physician
University of San Diego Student Health Center
Information Form for Prescription Management

Patient Name: _______________________________    DOB: __________________

Name of Medication: ___________________________________________

Diagnosis/Indication: ____________________________________________

The dates this patient has been under your care for management of this diagnosis
From: _______________________    To: _______________________

When was medication started? _________________________

Current Dosage: _________________________________

How long on current dosage? ________________________________

Last refilled? ___________________________

If applicable, is there a weaning plan for this medication (please indicate dose change and length of
time at each step)?
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

____________________________________________________________________________

Please list any complications from taking this medication:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
Any labs or other types of monitoring recommended, and if so at what frequency?
______________________________________________________________________________
______________________________________________________________________________

Have any other medications been tried in the past for the same condition?
______________________________________________________________________________
______________________________________________________________________________

Please list any other psychiatric diagnoses (including substance abuse issues) the patient may have and comment if the patient is in remission or stable, and for how long.
______________________________________________________________________________
______________________________________________________________________________

Please list any other chronic medical conditions the patient may have:
______________________________________________________________________________
______________________________________________________________________________

Please list any other medication the patient is taking and dosages:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

I understand that the information provided above is correct to the best of my knowledge.

Provider’s Name _______________________________ Lic # _______________

Signature _______________________________ Date _________________

Address
________________________________________________________________________

Phone # __________________________ Fax# _________________________