



5998 Alcalá Park  
Maher 140  
San Diego, Ca 92110-2492  
(619) 260-4595  
Fax (619) 260-2375

Dear Student,

Thank you for inquiring about the Student Health Center managing your Schedule II prescription for ADHD/ADD. Schedule II prescriptions are heavily regulated as they are considered higher risk for abuse and addiction and include stimulants that are used to treat ADHD/ADD. 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, including psychiatric conditions requiring medications or substance use (e.g. marijuana or other recreational drug use)

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**.
- Documentation that supports your diagnosis of ADD/ADHD such as neuropsychological testing, psychoeducational evaluation, documentation 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 sign below to give consent for us to communicate with the providers involved in your care. Please submit this signed letter, your supporting documentation, and the Information Form for Prescription Management for review on your MyWellness Portal (you can attach documents to a message). 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).

I, (print name) \_\_\_\_\_, give USD Student Health Center permission to contact the provider who fills out the Information Form for Prescription Management or other providers mentioned in the supporting documents to discuss issues related to my medication or the condition being treated.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Student ID # \_\_\_\_\_



5998 Alcalá Park  
Maher 140  
San Diego, Ca 92110-2492  
(619) 260-4595  
Fax (619) 260-2375

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 their Schedule II prescription for ADHD/ADD. 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 that is 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
- The patient 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, including psychiatric conditions requiring medication or substance use (e.g. marijuana or other recreational drug use)
- The student must provide additional documentation that supports the diagnosis or ADHD/ADD (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? \_\_\_\_\_

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 or use 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 \_\_\_\_\_ Provider's Specialty \_\_\_\_\_

Lic # \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

Fax# \_\_\_\_\_