ROCHESTER INSTITUTE OF TECHNOLOGY
STUDENT HEALTH CENTER
117 Lomb Memorial Drive
Rochester, NY 14623
Phone: 585-475-2255 Fax: 585-475-7788

PATIENT NAME: _____ DOB: _____

AUTHORIZATION TO PROVIDE PRESCRIPTIONS FOR TREATMENT OF ATTENTION DEFICIT DISORDER

The Rochester Institute of Technology (RIT) Student Health Center (SHC) has established procedures to assist students in obtaining prescriptions for controlled medications to treat Attention Deficit Disorder. Select providers on the SHC staff meet with students to refill prescriptions based on a diagnosis and treatment plan established by the patient's primary care physician or specialist at home.

FOR COMPLETION BY THE TREATING PROVIDER:
In completing this form, I, as the treating provider, also acknowledge an understanding that an Authorization Form **must be completed and updated as needed or requested** in order for SHC providers to continue to write prescriptions for **controlled** medications. SHC clinical staff follows Federal and New York State statutes and guidelines regarding the safe, ethical and legal prescribing of controlled medications.

The RIT SHC requires information about the diagnostic evaluation, treatment history and treatment plan. Please attach copies.

DIAGNOSIS:_____DATE:_____

CURRENT TREATMENT:_____

DIAGNOSTIC EVALUATION / TESTING:_____
_____

TREATMENT HISTORY: _____
_____

TREATMENT PLAN: _____

(For medication please include name, dose and timing)

REQUIRED: Please attach the diagnostic evaluation or psychoeducational assessment supporting the diagnosis and treatment history.

PROVIDER NAME: _____
ADDRESS: _____
PHONE NUMBER: _____ FAX NUMBER: _____

PROVIDER SIGNATURE: _____ DATE: _____

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RETURN COMPLETED FORMS ALONG WITH ADDITIONAL INFORMATION TO RIT STUDENT HEALTH CENTER BY FAX: 585 475-7788 OR MAIL.