DUQUESNE UNIVERSITY

600 Forbes Avenue
Pittsburgh, PA 15282
www.duq.edu

Dear Physician,

Duquesne University Health Service (DUHS) is pleased to provide psychopharmacology continuation services for enrolled students previously diagnosed with Attention-Deficit Hyperactivity Disorders (F90-*). This service is provided by a multidisciplinary medical team including clinical pharmacist and counselors under direction of the health service primary physician and in accordance with policies and procedures governing controlled substance prescriptions for ADHD. Please review the following requirements regarding student patient participation and forward all required documentation to DUHS.

Policy Requirements

- All patients will sign a controlled substance agreement
- Urine toxicology screening is required prior to the first prescription and thereafter at the discretion of the DUHS medical team
- PA PDMP search and pill count reconciliation will occur prior to each prescription
- Prescriptions will be provided for 30 days without refills
- NO controlled substance prescriptions for ADHD may be provided by any other prescribing clinician including PCP, psychiatrist at any time without direct communication with DUHS.

Required Documentation

- ❑ Letter from current medical provider (PCP or Psychiatrist) describing ADHD diagnostic history and comprehensive medication treatment history
- ❑ Copies of last two medical appointment documentations with relevant and detailed prescriptions provided
- ❑ Copies of all rating scales used in diagnosis

Sincerely,

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Duquesne University Health Services
Center for Student Wellbeing
A.D.H.D Protocol – PATIENT INFORMATION

Duquesne University Health Services (DUHS) recognizes increasing numbers of students presenting with symptoms of or with a previous diagnosis of ADHD. DUHS also recognizes the challenge of obtaining recommended pharmacotherapy while enrolled at DU. As a result, DUHS has implemented new policies and procedures for all patients with a diagnosis of ADHD requesting continuation of pharmacotherapy while enrolled full time at DU.

What is ADHD?

- Symptoms of inattention and /or hyperactive-impulsive behavior that cause significant impairment in two or more major life activities, including interpersonal relations, educational and occupational goals, and cognitive or adaptive functioning.

What is the DUHS policy regarding confirmation of an ADHD diagnosis and documentation requirements?

- Previously diagnosed with ADHD o We need to review detailed records from previous providers including a letter from your current medical provider describing your ADHD diagnosis history and comprehensive medication treatment history. A copy of your last two medical appointments with relevant prescriptions and copies of all rating scales used in diagnosis should be faxed to DUHS prior to your first appointment (412-396-5655).
- Never diagnosed with ADHD o You may seek diagnostic evaluation at a local primary care provider, psychiatrist or at the following resources:
    - WPIC ADHD Across the Lifespan Clinic (412-246-5218)
    - Allegheny Health Network – Neuropsychological testing – Outpatient Services (412-330-4409)
    - Laura Crothers D.Ed, NCSP, Duquesne University (412.396.1409 crothersl@duq.edu)

  o DUHS does not currently support diagnostic evaluation for ADHD.
- You will be asked to sign an authorization for release of records and communications with other relevant physicians, psychologists, and pharmacies involved in your care.

What is the DUHS policy regarding treatment of ADHD?

- ADHD treatment always includes a multidisciplinary, comprehensive approach to treatment which may include counseling and education on behavior modification at home, school, and work. Treatment may also include referral to DU Center for Disability Services (412-396-6658) for academic accommodations in learning and testing (preferential class seating, testing rooms, extended time on tests, etc.)
- If treatment includes controlled substances you will be required to sign a controlled substances agreement and your name will be entered into the PA Prescription Drug Monitoring Program prior to all prescriptions.
- You will be required to complete a urine toxicology screening panel prior to obtaining your first prescription and at any time thereafter at the discretion of the prescriber. If you decline, controlled substances will not be prescribed.

- Controlled substance prescriptions are provided only during scheduled office hours and for 30 days or less without refills. These prescriptions must be filled at the Center for Pharmacy Care.
- You will need to bring the original pill bottle and any unused pills to each appointment; a Pharmacist from the Center for Pharmacy Care will perform a pill count at that time.

What are the side effects of medications for ADHD?

- ADHD stimulant medications can cause decreased appetite, stomachaches, sleep disturbances, nervousness, and headaches. Sometimes there can be behavioral rebound that can be worse than initial symptoms, but this is less common.
- More serious side effects include increased heart rate and blood pressure, hallucinations, dizziness, growth suppression, tics/twitches (involuntary movements), weight loss.

If not ADHD, then what could it be?

- A large number of patients with ADHD also suffer from other comorbid conditions including behavioral disorders, depression, anxiety, and others. Student are encouraged to request evaluation at Health Services (412-396-1650) or Counseling and Wellbeing Center (412-396-6204) regarding additional behavioral health concerns.

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Tips for Duquesne University Students with ADHD:

- ***Educate yourself on ADHD*** o Ask your primary care provider any questions you have about ADHD o Discuss ADHD with family and friends to learn if they have noticed strategies that work better for you and get feedback about what they think may help you

- ***Organizational skills*** o Map out how you will use your time in college o Break down assignments into smaller, more manageable parts o Use highlighters when reading textbooks o Use audio version of books o Use reminder notes on your phone o Using "to-do" lists, reminder systems, schedulers, calendars to keep track of tasks and events o Organizing your home logically and consistently by always keeping certain items in the same place, specific area for work, keys, wallet, etc.
  o Create filing systems to keep paperwork and clutter under control

- ***Impulsive Behaviors*** o Implement strategies to reduce spontaneous decision making o Avoid impulsive spending by limiting number of credit cards and using online banking o Perform relaxation techniques like music or meditation

- ***Hyperactive Behaviors*** o Find an activity or outlet to help release excess energy; exercise 3X/week.
  o Create strategies for when sitting still is a necessity

- ***Daily Living*** o Consider college as your job, and work at least 40 hours/week on classes and classwork. o Remind yourself of your strengths and things you do well – be proud of yourself!
  - Avoid things that could have a negative impact on your disease such as alcohol, drugs, caffeine, and procrastination which all could add increased pressure to your daily life
  - Try to minimize distractions in your study environment including minimizing electronic devices, TV, etc.
  - Accept that some tasks will be more difficult, anticipate problems, and allow for ample time to regroup and complete.
  - Ask for help!
    - Friends, family, providers, support group, coworkers
    - Consider tutors for structured study time
    - Consider use of writing center for editing papers
    - Consider study groups

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

Duquesne University Health Service
PSYCHOSTIMULANT THERAPY AGREEMENT

Your Provider, _____, has recommended a controlled substance (stimulant) as a part of your treatment plan. This agreement lists our policies and what we expect of you.

STUDENT AND DUQUESNE HEALTH SERVICE EXPECTATIONS:

- **Purpose of Treatment**: I understand that the goals of my treatment with Controlled Substances are to increase my ability to organize and function in school and work, and follow my Provider's treatment plan.
- **Comprehensive Treatment Plan**: I understand that taking Controlled Substances is only one part of my overall treatment. The renewal of my Controlled Substance prescriptions depends on both my medical needs and my active participation in my provider's treatment plan.
- **Disclosure of Medications**: I have told my provider all medications that I use for any reason. In the future I must inform my provider of any and all changes. I understand that this list will become part of my permanent medical record. I give my provider permission to discuss my medication history, and current medications with any physician or pharmacy.
- **Your Provider, _____, is the only Provider of Controlled Substances**: I will not attempt to obtain prescriptions for Controlled Substances from any source other than my provider. If I require treatment with Controlled Substances because of emergency medical or dental care, I will tell my provider within seventy-two (72) hours. I will not take drugs prescribed to someone else.
- **Use of Medications**: I will take Controlled Substances exactly as my provider prescribed. This means I will not change the dose, frequency or change the form of drugs (such as opening capsules, cutting tablets in half, crushing tablets and capsules, or chewing medications). I understand that doing any of these might result in harmful effects including overdose and death.
- **Pharmacy Identification**: I agree to fill all of my controlled Substances prescriptions exclusively at the Center for Pharmacy Care.
- **Refills Policy**
  - ✓ My provider will not fill any prescriptions early if I run out of Controlled Substances before my next scheduled refill or appointment.
  - ✓ My provider will only renew my Controlled Substance prescriptions visit during Health Service's regular clinic hours. No refills of any controlled substance will be written or called in after regular clinic hours or on the weekends. I will also allow for 72 hours for a medication to be refilled.
  - ✓ My provider will not replace lost, stolen, damaged, or otherwise drugs or prescriptions that are made useless.
- **Drug Testing/Pill Counts**
  - ✓ I agree to comply with any and all drug testing. I agree to provide my own urine samples even if requested on days when I have no scheduled appointment.
  - ✓ If a drug screen is refused it will be considered positive and Controlled Substances may be discontinued.
  - ✓ I agree to comply with pill counts in the original medication bottle to be done by the CRNP, Health Service, at each appointment.
- **Illegal Drug Use and/or Activity**
  - ✓ **I will not use any illegal substances/drugs or controlled prescription drugs not approved by my provider. I will not share, sell, or trade any of my medications, including controlled Substances prescribed by my provider, with anyone.**
- **Use of alcohol**

- ✓ Controlled substances should not be taken with alcohol. I understand the risks of drinking alcohol while taking Controlled Substances. Should I drink alcohol while taking the Controlled Substances prescribed to me, I do so despite these risks. These risks include serious injury, drug overdose and death.

- **Notification of Change in Mental Status**
  - ✓ Controlled substances may impair your mental and physical abilities including my ability to drive safely. If I have side effects from any of my medications, I will let my provider know. These side effects might include: drowsiness, feeling tired, nausea, vomiting, constipation, confusion, feeling very up/high or down/depressed. If I have any of these symptoms, I will not drive or operate heavy machinery.
- **Authorization to Share Protected Health Information**
  - ✓ I agree to waive my right to privacy and authorize the above named provider to discuss my medical care and to disclose my use of medications, or possible misuse with any health care provider, Pharmacy, legal authority, or regulatory agency in his/her discretion. I further authorize the above named provider to cooperate fully with any city, county, state, or federal law enforcement agency (including DEA), in the investigation about my care or actions.
- **Termination of Treatment**
  - ✓ I understand that my provider at his/her discretion may stop treating me with Controlled Substances, refer me to a substance abuse specialist, and/or dismiss me from the care of the Health Service if I break any portion of this agreement or am arrested for any unlawful conduct.

My signature confirms that I understand and agree to all of the above requirements of the Controlled Substances Agreement.
My signature below acknowledges that:

- I have signed this controlled substances Agreement voluntarily after having sufficient time to review it.
- I agree to all of the above requirements of the Controlled Substances Agreement with full understanding of the risks of being prescribed Controlled Substances.
- I have read, understand and agree to the statement set forth above in this document.
- I have had the opportunity to ask questions about this document of a physician or a physician's designee.

Patient Full Name: _____ **Date:** _____
Patient Signature: _____

I have received a copy of this signed Agreement. Patient Initial: _____

Health Service Provider Signature: _____ **Date:** _____
Health Service Medical Director Signature: _____ **Date:** _____