WICKER WELLNESS CENTER
807 Union St., Schenectady, NY 12308
Phone: (518)388-6120 Fax: (518)388-6147
Email: uchealthcenter@union.edu

PRESCRIBING OF PSYCHIATRIC MEDICATION

Important Information --- Please Read Carefully

Dear Student:

All students who are requesting to have Health Services participate in writing prescriptions for psychiatric medications are required to have a completed release form from their prescribing physician.

The following information ***must*** be included:

- Student's name
- Student's date of birth
- Medication and dosage
- First date to renew the medication
- Provider's signature

Please mail the form directly to:

Angela Stefanatos, MS, PMHNP-BC
Wicker Wellness Center
Union College
807 Union St.
Schenectady, NY 12308

Thank you for your cooperation.

Sincerely,

Angela Stefanatos, MS, PMHNP-BC
Director of Health Services

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RELEASE FOR PRESCRIBING OF PSYCHIATRIC MEDICATIONS

**TO BE COMPLETED BY HEALTHCARE PROVIDER **

It is not unusual for a student to come to the Wicker Wellness Center already being treated for ADHD or other psychiatric conditions. Since many of the medications being used to treat these conditions require close monitoring, as well as monthly renewals, the following document must be completed and returned to the Wicker Wellness Center before we can assume prescribing responsibility.

ADDITIONAL DOCUMENTATION

In addition to this form being completed, please attach any records, testing or diagnostic documentation that may be available to provide a summary of this patient's treatment.

STANDARD OF PRACTICE

The standard of practice that we follow is to work collaboratively with the prescribing provider in order to bridge the prescribing responsibilities for students while they are at school.

Student's Name:_____ Date of Birth:_____

Address:_____

City/State/Zip:_____

Diagnosis:_____ Age of Diagnosis:_____

Current Medication:_____ Dosage:_____

Current Medication:_____ Dosage:_____

Current Medication:_____ Dosage:_____

Date(s) of Last Prescription:_____

Prescribing Provider's Name:_____

Student Signature:_____

HEALTH CARE PROVIDER SIGNATURE REQUIRED **Stamp Here:**

Name (please print)_____

Address_____

City_____State_____Zip Code_____

Phone( )_____ Fax( )_____

PROVIDER SIGNATURE_____**DATE**_____