Thank you for choosing your Medical Student Wellness Program for your care. It is important for you to read each item carefully and initial in the space provided to the left each item. By initialing you are indicating you have read, and understand the content of each item. If you have any questions about the items below, please discuss with your provider at your appointment.

**General:**

\_\_\_\_\_ I am consenting to be evaluated to undergo possible medication treatment for my mental health issues. Medication options will be discussed with my provider. Some of these options may include antidepressants or psychotropic medications. I may also be recommended to participate in other forms of mental health care treatment.

\_\_\_\_\_ MSWP does not offer after-hours services. If you have a concern you can email your provider directly and you can typically expect a response within 24-48 hours or 1-2 business days.

\_\_\_\_\_ If you have an emergency, such as suicidal thoughts, thoughts to hurt someone else, or a sever drug reaction, you should call 911 or go to your local urgent care or emergency room.

**Medication Refill Requests:**

\_\_\_\_\_ You can contact your provider directly for all refill requests.

\_\_\_\_\_ You may be required to meet with your provider before a refill request can be filled.

\_\_\_\_\_ Refill requests can take up to 5 business days and may take longer if an in-person appointment is required.

**Appointment Scheduling and Cancelations:**

\_\_\_\_\_ To schedule or reschedule an appointment with your provider, please email Brittany Meldrum ([brittany.meldrum@hsc.utah.edu](mailto:brooke.lewis@hsc.utah.edu)).

\_\_\_\_\_ Please allow AT LEAST 24 hours or as much notice as possible if you need to cancel an appointment to allow others the opportunity to be seen by your provider.

\_\_\_\_\_ If you are going to be late, please email your provider directly to notify them.

\_\_\_\_\_ MSWP may discharge you from our program if you miss multiple appointments with your provider.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Today’s Date

Name Date of Birth

Nickname/Preferred Name

**Reason for Visit**

I would like to discuss the following symptoms or concerns in my initial visit:

Approximately when did these symptoms first begin?

Have these symptoms worsened recently?

How do these symptoms impair your ability to function, work, or relate to other people?

Can you briefly describe any significant stressors that have happened in the last year or so?

**Current Medications**

IF YOU ARE TAKING ANY PSYCHAITRIC MEDICATIONS WE MUT HAVE A RELEASE OF INFORMATION FOR RECORDS FROM THE MOST RECENT PRESCRIBER.

Please list ALL of your current medications and supplements in the table below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **MEDICATION** | **DOSE** | **NUMBER OF PILLS TAKEN** | | | |
| **MORNING** | **NOON** | **AFTERNOON** | **BEDTIME** |
| Example Medication (1 twice per day, 2 at night) | 0.5 MG | 1 | 0 | 1 | 2 |
|  |  |  |  |  |  |
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**Release of Information**

**In order for us to provide the best care to you, we will need you to complete Release of Information forms to review records and possible to discuss your care with current and past health care providers. Without your consent for these Releases of Information we may decide that we will be unable to provide care to you. Releases of Information forms can be emailed directly or can be found with your therapist.**

1. If you listed any current psychiatric medications you will need to complete a Release of Information for the current or most recent prescriber of these medications.
2. Have you been prescribed psychotropic medications in the past?

Yes (if yes, complete a Release of Information for the last prescriber you saw)

No

1. Are you currently seeing a therapist or counselor outside the MSWP?

Yes (if yes, complete a Release of Information to exchange information with your therapist)

No

1. Have you ever been psychiatrically hospitalized?

Yes (if yes, complete a Release of Information for the most recent hospitalization)

No

1. Have you ever been in a chemical dependency treatment program?

Yes (if yes, complete a Release of Information for the most recent hospitalization)

No

1. Please complete a Release of Information to exchange information with your current Primary Care Provider if you have not already done so.

**Medication History**

Please indicate if you have EVER taken any of the following psychotropic medications, the highest dose you remember taking, and the approximate dates it was prescribed:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Depression and Anxiety Medication** | | **Highest Dose** | | **Dates** | | **Side Effects/Benefits/Comments** | |
|
| Ascendin | |  | |  | |  | |
| Anafranil/clomipramine | |  | |  | |  | |
| Brintellix/vortioxetine | |  | |  | |  | |
| Celexa/citalopram | |  | |  | |  | |
| Cymbalta/duloxetine | |  | |  | |  | |
| Desyrel/trazodone | |  | |  | |  | |
| Effexor/venlafaxine | |  | |  | |  | |
| Elavil/amitriptyline | |  | |  | |  | |
| Emsam/selegiline | |  | |  | |  | |
| Fetzima/levomilnacipran | |  | |  | |  | |
| Lexapro/escitalopram | |  | |  | |  | |
| Luvox/fluvoxamine | |  | |  | |  | |
| Marplan/isocarboxazid | |  | |  | |  | |
| Nardil/phenelzine | |  | |  | |  | |
| Norpamin/desipramine | |  | |  | |  | |
| Pamelor/nortriptyline | |  | |  | |  | |
| Parnate/tranylcypromine | |  | |  | |  | |
| Paxil/paroxetine | |  | |  | |  | |
| Pristiq/desvenlafaxine | |  | |  | |  | |
| Prozac/fluoxetine | |  | |  | |  | |
| Remeron/mirtazapine | |  | |  | |  | |
| Sarafem/fluoxetine | |  | |  | |  | |
| Savella/milnacipran | |  | |  | |  | |
| Serzone/nefazodone | |  | |  | |  | |
| Sinequan/doxepin | |  | |  | |  | |
| Surmontil/trimipramine | |  | |  | |  | |
| Tofranil/imipramine | |  | |  | |  | |
| Viibryd/vilazodone | |  | |  | |  | |
| Vivactil/protriptyline | |  | |  | |  | |
| Wellbutrin/bupropion | |  | |  | |  | |
| Zoloft/sertraline | |  | |  | |  | |
| **Alcohol Abstinence Medication** | **Highest Dose** | | **Dates** | | **Side Effects/Benefits/Comments** | |
|
| Revia/naltrexone |  | |  | |  | |
| Antabuse/disulfiram |  | |  | |  | |
| Campral/acamprosate |  | |  | |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **ADHD Medications** | Please note: you MUST have had ADHD testing with a psychologist before we can prescribe these medications. NAL can provide this testing if needed. We do NOT prescribe these medications if you are taking narcotic pain medications, methadone, or suboxone. | | |
|
| Adderall/amphetamine |  |  |  |
| Adderall XR/amphetamine ER |  |  |  |
| Concerta/methlylphenidate ER |  |  |  |
| Daytrana/methylphenidate patch |  |  |  |
| Desoxyn/methamphetamine |  |  |  |
| Dexedrine/dextroamphetamine |  |  |  |
| Dextrostat/dextroamphetamine |  |  |  |
| Focalin/dexmethylphenidate |  |  |  |
| Focalin XR/dexmethylphenidate ER |  |  |  |
| Intuniv/guanfacine |  |  |  |
| Metadate/methylphenidate |  |  |  |
| Methylin/methylphenidate |  |  |  |
| Ritalin/methylphenidate |  |  |  |
| Ritalin SR/methylphenidate ER |  |  |  |
| Ritalin LA/methylphenidate LA |  |  |  |
| Strattera/atomoxetine |  |  |  |
| Vyvanse/lisdexamfetamine |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **AntiAnxiety Medication** | Please note: we do NOT prescribe these medications if you are taking narcotic pain medications, methadone, suboxone, or ADHD medication. | | |
|
| Atenolol |  |  |  |
| Ativan/lorazepam |  |  |  |
| Buspar/buspirone |  |  |  |
| Catapres/clonidine |  |  |  |
| Inderal/propranolol |  |  |  |
| Klonopin/clonazepam |  |  |  |
| Librium/chlordiazepoxide |  |  |  |
| Serax/oxazepam |  |  |  |
| Tranxene/clorazepate |  |  |  |
| Valium/diazepam |  |  |  |
| Vistaril/hydroxyzine |  |  |  |
| Xanax/alprazolam |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Antipsychotic/Mood Stabilizer** | **Highest Dose** | **Dates** | **Side Effects/Benefits/Comments** |
|
| Abilify/aripiprazole |  |  |  |
| Clozaril/clozapine |  |  |  |
| Fanapt/iloperidol |  |  |  |
| Haldol/haloperidol |  |  |  |
| Invega/paliperidone |  |  |  |
| Latuda/lurasidone |  |  |  |
| Loxitane/loxapine |  |  |  |
| Mellaril/thioridazine |  |  |  |
| Moban/molindone |  |  |  |
| Navane/thiothixine |  |  |  |
| Prolixin/fluphenazine |  |  |  |
| Rexulti/brexpiprazole |  |  |  |
| Risperidol/risperidone |  |  |  |
| Saphris/asenapine |  |  |  |
| Seroquel/quetiapine |  |  |  |
| Seroquel XR/quetiapine XR |  |  |  |
| Stelazine/trifluoperazine |  |  |  |
| Thorazine/chlorpromazine |  |  |  |
| Trilafon/perphenazine |  |  |  |
| Zyprexa/olanzapine |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Mood Stabilizers and Anticonvulsants** | **Highest Dose** | **Dates** | **Side Effects/Benefits/Comments** |
|
| Depakote/valproate |  |  |  |
| Keppra/levetiracetam |  |  |  |
| Lithium/Eskalith/Lithiobid |  |  |  |
| Lamictal/lamotrigine |  |  |  |
| Symbax |  |  |  |
| Neurontin/gabapentin |  |  |  |
| Tegretol/carbamazine |  |  |  |
| Topomax/topiramate |  |  |  |
| Trileptal/oxcarbazepine |  |  |  |
| Zonegran/zonisamide |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Sleep/Wake Medications** | **Highest Dose** | **Dates** | **Side Effects/Benefits/Comments** |
|
| Ambien CR/zolpidem ER |  |  |  |
| Ambien CR/zolpidem ER |  |  |  |
| Belsomra |  |  |  |
| Dalmane/flurazepam |  |  |  |
| Desyrel/trazodone |  |  |  |
| Gabitril/tiagabine |  |  |  |
| Halcion/triazolam |  |  |  |
| Intermezzo |  |  |  |
| Lunesta/eszoplicone |  |  |  |
| Nuvigil/armodafinil |  |  |  |
| Periactin/cyproheptadine |  |  |  |
| Provigil/modafinil |  |  |  |
| Restoril/temazepam |  |  |  |
| Rozerem/ramelteon |  |  |  |
| Silenor/doxepin |  |  |  |
| Sinequan/doxepin |  |  |  |
| Sonata/zaleplon |  |  |  |
| Xyrem/sodium oxybate |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medications used for Side Effects** | **Highest Dose** | **Dates** | **Side Effects/Benefits/Comments** |
|
| Cogentin/benzotropine |  |  |  |
| Benadryl |  |  |  |
| Artane/trihexyphenidy |  |  |  |
| Inderal/propranolol |  |  |  |
| Atenolol |  |  |  |

**Allergies**

Please List All Medication Allergies:

**Surgical History**

Please list all surgeries you have had:

Surgical Procedure Year

**Medical History**

Please list all of your physical illnesses/conditions (problems with your heart, lungs, liver, stomach, bowel, skin, joints, thyroid, etc. including if you are currently pregnant).

Condition Year Diagnosed

Family Mental Health History:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Mother | Father | Sibling | Other (list) | What Treatment? |
| Anxiety |  |  |  |  |  |
| Depression |  |  |  |  |  |
| Bipolar Disorder |  |  |  |  |  |
| Substance Abuse |  |  |  |  |  |
| Other: |  |  |  |  |  |

Family Medical Health History:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Mother | Father | Sibling | Other (list) |
| Diabetes |  |  |  |  |
| Heart Problems |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| High Cholesterol |  |  |  |  |
| Thyroid |  |  |  |  |
| Other: |  |  |  |  |
| Other: |  |  |  |  |

1. How often do you exercise?

\_\_\_\_\_\_ times per week

1. How many caffeinated beverages do you have per day?

\_\_\_\_\_\_

1. Do you use tobacco?

Yes

No

1. How many alcoholic beverages do you consume in a week?

\_\_\_\_\_\_\_

1. Have you ever had a seizure or have you ever been diagnosed with epilepsy?

Yes (if yes, please describe below)

No

1. Are you or is there a chance you are pregnant?

Yes

No

1. Have you ever had a period of unconsciousness (coma, knocked out, brain injury, concussion?)

Yes (if yes, please describe below)

No

1. Are you concerned about past or present alcohol or drug use?

Yes (if yes, please describe below)

No

1. Are you concerned about past or present eating behaviors?

Yes (if yes, please describe below)

No

Additional Comments

**CONTROLLED MEDICATION AGREEMENT**

**Controlled substance medications have potential for misuse. They are intended to improve function and/or ability to work, and are not simply to feel good.**

* Our providers may not prescribe standing doses of benzodiazepines with stimulant medications.
* Our providers do not prescribe pain medication or medical cannabis.
* If you are taking narcotic pain medication, medical cannabis, or are abusing drugs or alcohol, our providers may not prescribe controlled medications to you.
* If you are pregnant or have certain medical or psychiatric conditions, controlled medications may not be appropriate for you.
* Your medication provider may request records from other medical providers, permission to talk to family members, drug screens and other laboratory tests, psychological tests, and may review the state controlled medication profile, before starting or continuing controlled medication.
* Drug screens, laboratory test, and counts of remaining pills may be requested while you are taking controlled medications, and must be completed within 24 hours.
* Our providers must follow maximum dosing guidelines for controlled medications.

I have been told and understand that:

1. I may get addicted to this medication. Your risk for addiction is higher if you have a family history of alcohol or drug addiction. If I need to stop this medication, I must do it in under the direction of a medical provider, including the possible need for admission to a medical detox facility, or I may get very sick.
2. I can be found guilty of Driving Under the Influence (DUI) if taking these medications and driving, even if no alcohol has been consumed.
3. I may not be prescribed controlled medication if I am currently living in a residential chemical dependency treatment center or participating in chemical dependency treatment program. I understand I must remain sober for 12 months minimum after completing a residential or outpatient chemical dependency program before controlled medications will be considered, if at all.
4. I am responsible for scheduling my next appointment so I do not run out of medication between office visits.
5. I will participate in all other types of treatments for my condition that I am asked to participate in.
6. If I am arrested or incarcerated related to illegal drug charges (including alcohol), controlled medications will be stopped and cannot be restarted during the duration of my care with the MSWP
7. My provider may not grant early refills for any reason (i.e. lost, stolen, damaged) for any controlled medication.
8. If I am taking medical cannabis, methadone, suboxone or other any other narcotic based medications on an ongoing basis, controlled medications will be stopped while I am taking these other medications. Taking stimulants or tranquilizers with these medications can be life threatening and cancel out their effects. If I do not tell my provider about using any drugs or controlled medications on my own or from any other providers, my care will be permanently ended.
9. If I sell, trade, share, fill early, or increase the dose of controlled medications on my own, they will be stopped and cannot be restarted during the duration of my care with the MSWP
10. If I have an emergency such as severe suicidal thoughts, thoughts to hurt someone else or if I am having a severe drug reaction, I will call 911 or go to the emergency room. I will notify my provider as soon as possible.
11. I will treat the MSWP staff respectfully at all times. I understand if I am disrespectful (including but not limited to yelling, foul language, bullying or harassing) to any staff or if I disrupt the care of other patients, my treatment will be permanently stopped
12. I may be asked to only use one pharmacy to get my medicine. My provider may talk with the pharmacist about my medicines.
13. Drug screens requested by my provider must be completed within 24 hours or will be considered positive.
14. I will inform all my other physicians of the controlled substance medication I am receiving through MSWP. Likewise, I will inform my MSWP medication provider of any other controlled substance medication I receive from another physician.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date Provider Initials