

**Sarah Lawrence College Health Services
Mental Health Treatment History**

I, _____, authorize the completion and transmission of the following clinical information to Sarah Lawrence College Health Services.

Student Signature

Date

Diagnosis: _____
(If ADHD, please provide available testing data)

Length of Current Treatment:

Prior Treatment History:

Clinical Impression:

Current Medication and dosages:

Previous Medications and dosages:

Recommendations for Medication Treatment:

Any known Chemical Dependency Issues:

Clinician Signature

Date

License #:

Address:

Phone/Fax:

**Please print form and return by fax or mail to:
Sarah Lawrence College Health Services
Attn: Allan Flaggman, MD
1 Mead Way Bronxville, NY 10708
914-395-2350 (phone) 914-395-2640 (fax)**