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**Referral to the ADHD Service**

**(please use a transfer of care form if patient already has a diagnosis and is stable on medication treatment)**

**Please return to:** **awp.specialisedADHDservices@nhs.net**

**Please complete all sections**

**We cannot accept referrals in letter or other forms.**

**PART 1 – to be completed by the GP/referrer**

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| **Reason(s) for referral:** |
| Assessment |  | Titration  |  | Psycho-social (pre or post titration and diagnosed) |  |
| **Section 1a. Additional Referral Considerations**  |
|  | **Tick** |  | **Tick** |
| Expectant/new mothers (or primary care provider) for a child under 12 months |  | Children are subject to a child protection plan/child in need plan |  |
| Prison leaver/engaged in criminal justice system (within the last 6 months). |  | Current or recent involvement from Substance Misuse Services (within the last 6 months) |  |
| Armed Service Veterans  |  | Current or recent Adult Safeguarding involvement (within the last 6 months) |  |
| Domestic Abuse history (victim or perpetrator) |  | *Recently discharged from inpatient unit under section 2/3 (within the last 6 months)* |  |
| *Local Enhanced Service Referrals - Patients under the LES pathway do not need a referral back into the service, an email/letter is sufficient, however a* ***discussion between the GP and an ADHD clinician should precede any LES requests*** *back into the ADHD service.* |
| **Section 1b. Reasonable adjustments** |
| ***Does this person have any additional needs or diagnosis e.g. learning disability etc and requires any reasonable adjustments for appointments or communications  e.g. face to face appointments, interpreter, easy read information/letters etc:*** |
|  |
| **Section 1c. Service User Details** |
| **Date of Referral:**  |
| Name |  | DOB |  |
| NHS number |  | Current Address |  |
| Gender |  | Marital Status |  |
| Sex (at Birth)  |  | Sexual Orientation |  |
| Race / Ethnicity  |  | Religion / Belief System |  |
| Next of Kin (NoK) |  | Contact Detail of NoK  |  |
| Housing Status |  | Language  |  | Interpreter needed? [ ]  |
| Nationality  |  | Contact phone number |  | OK to leave message [ ]  |
| Contact email address |  | OK to send to [ ]  |
| **Referrer Details** |
| Name |  | Contact phone number |  |
| Organisation |  | Contact email address |  |
| Address |  |
| Has the service user consented to the referral? | Yes [ ]   | No[ ]  |
| Does the patient consent to receiving non-secure NHS emails from the ADHD service?  | Yes [ ]   | No[ ]  |
| Previous diagnosis of ADHD | Yes ☐ | No☐ |
| **If this assessment results in a positive diagnosis and medication treatment, does the GP consent to shared care prescribing following complete titration**  | Yes[ ]  | No[ ]  |
| **Section 2. Reason for Referral** |
| *i.e. inattention (problems with focused or sustained concentration, organisation, planning etc) , hyper-activity (fidgetiness, restlessness, sitting still for long periods etc ), impulsivity (risk taking, problems with decision making, speaking over people etc).* |
| Main Presenting Problems as an Adult(*Employment, relationships, chores/tasks, self-concept etc.)*  |  |
| Presenting problems in Childhood (before age of 12) |  |
| History of Presenting Complaints as an Adult | Onset |  |
| Duration  |  |
| Separate Episodes or Persistent? |  |
| **Section 3. Risk Assessment** |
| **Risk to self**i.e. past and current suicidality, intent, self-harm, self neglect etc. |  |
| **Risk to others**i.e. past and current harm to others, domestic violence, child safeguarding, driving etc |  |
| **Criminal activity**Past or current cautions, convictions, prison sentences etc |  |

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| **Section 4. Medical History** |
| *Any Previous Problems with?* |
| Acquired Brain Injury |[ ]  Chest Pain |[ ]  Heart Attack |[ ]
| Epilepsy |[ ]  Cardiac Arrhythmia |[ ]  Stroke |[ ]
| Meningitis |[ ]  Palpitations |[ ]  High Blood Pressure |[ ]
| Encephalitis |[ ]  Fainting/syncope |[ ]  Glaucoma |[ ]
| **None of the above** [ ]  |
| If Yes to any, please describe problem and investigations and treatment. |  |
| Any other physical health diagnoses? |  |
| Sleep related problems? |  |
| Allergies? |  |
| Current Medication? |  |
| If stopped taking ADHD medication when were they last prescribed (date)? |  |
| **Section 5. Psychiatric History** |
| Co-morbid Psychiatric Problems?*(anxiety, mood disorder, psychotic symptoms, interpersonal issues, trauma etc)* |  |
| Previous Treatment and Effectiveness?(*medication, talking therapy etc.)* |  |
| Contact with Mental Health Services in past 6 months | Primary Care / IAPT[ ]  | Secondary Care / Specialist Services[ ]  |
|  | Other (please state) |  |
| **Please attach latest GP Summary** |