**REFERRAL FORM**

**Service for Adults with ADHD (ELFT)**

We need information to ensure referrals are managed in an efficient manner and reduce unavoidable delays. If you need advice about the referral process or suitability of your referral you are welcome to contact the catchment area CMHT by telephone to discuss the referral.

We accept referrals from GP/Health care professionals but need the agreement of the GP to undertake shared care of the patient.

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| **Reason For Referral** | **Y/N** | **Please provide copy of the diagnostic report if available** |
| Diagnostic assessment of Adult ADHD |  |  |
| Medication review for someone already diagnosed with ADHD |  |  |
| Transfer of ADHD followed up |  |  |

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| **Referrer Details** | | | |
| Name |  | Designation/ Job Title |  |
| Address |  | Telephone |  |
| GP name and address, if different to above |  | | |

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| **Person being referred** | | | | |
| Name |  | | NHS Number |  |
| Current Address |  | | Date of Birth |  |
| Telephone Numbers | Home:  Mobile:  Work | | Has consent been given by patient for this referral | Yes / No |
| Does the person have any communication needs and /or require information in a format other than standard print | | Yes / No  Please give details: | | |
| Does the person want someone to contact us on their behalf when arranging an initial appointment? | | Yes / No  Details of contact (Name/address/telephone number): | | |

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| **Referral Information**  **All referrals must include information in sections A, B and C to be considered for screening, incomplete referrals will be returned.**  **Please complete Sections A & B in consultation with patient.** | | | | | | |
| **Section A**  **ADHD Core features**  Please request the service user to answer the questions written below, and please fill it in on the behalf of the service user each of the criteria shown using the scale below.  As per the answer, place an X in the box that best describes how the service user has felt and conducted himself **over the past 6 months**. | | | | | | |
|  |  | **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 required 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? |  |  |  |  |  |
| **Section B**  **Impact**  **Please provide a summary of how the service user feels these difficulties impact on their daily life, for example:**  **a) Obtaining or sustaining education:**  **b) Obtaining or sustaining employment:**  **c) Initiating or sustaining social relationships:**  **d) Any impact on daily life:** | | | | | | |
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| **Section C:** | | | | |
| Any previous diagnosis of a mental health or neurodevelopmental condition (e.g. Autism, Dyslexia, Dyspraxia) | | Yes / No  Details: | | |
| Family History of ADHD | | Yes / No  Details: | | |
| Substance Misuse History | | Yes / No  Details: | | |
| Any physical health problems including any medication currently prescribed (If applicable) | | Yes / No  Details: | | |
| History of Cardiovascular Disease | | Yes / No  Details: | | |
| Family history of Cardiovascular disease before age 55 | | Yes / No  Details: | | |
| History of tics or epilepsy | | Yes / No  Details: | | |
| History of liver disease | | Yes / No  Details: | | |
| **Baseline Physical Health Checklist**  Please include the reading on he following | | | | |
| Blood Pressure |  | | Pulse rate |  |
| Weight |  | | Height |  |
| ECG (If patient has existing cardiac condition | | | | |

**Please use the space below to provide any other relevant information**

**(e.g. current risks, access to support, what the person wishes to obtain from the assessment)**

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Please send the completed referral to your local Community Mental Health Team for consideration.