Shared Care Guideline for Methylphenidate, Atomoxetine, Dexamfetamine, Lisdexamfetamine & Guanfacine for ADHD in Children and Adolescents (GP Summary)

It is essential that a transfer of care only takes place with agreement of the GP and when sufficient information has been received. If the GP does not agree to share care they will inform the Consultant responsible for the patient's care.

Indications	Attention Deficit Hyperactivity Disorder (ADHD) in children and adolescents aged 5 to 18 years. The best interest, agreement and preferences of the patient should be at the centre of any shared care agreement and their wishes followed wherever possible. Patients should be able to decline shared care if, after due consideration of the options, they decide it is not in their best interests. This shared care guideline is in accordance with NICE Guideline NG87 and the NHSE document 'Responsibility for prescribing between Primary & Secondary/Tertiary Care' (Jan 2018) and relates to adult / adolescents / child patients after titration and dose stabilisation, whose condition is stable at hand over from secondary/tertiary to primary care. When making arrangements for the prescribing of medicines for someone who may be at risk of self-harm or have the potential to misuse the medication, the arrangements should fit within the overall care plan for the individual service user. **Children and adolescents** Methylphenidate and Atomoxetine are licensed for the treatment of ADHD in children of 6 years or over, as part of a comprehensive treatment programme. Lisdexamfetamine and Dexamfetamine are indicated as part of a comprehensive treatment programme for attention deficit/hyperactivity disorder (ADHD) in children aged 6 years and over when response to previous methylphenidate treatment is considered clinically inadequate. Guanfacine is licensed for the treatment of ADHD in children and adolescents 6-18 years old for whom stimulants are not suitable, not tolerated or have been shown to be ineffective. **This shared care guideline excludes:** • Treatment of children under 5 years • Treatment of patients with doses of ADHD medication outside the licensed recommendations. • Initiation of another ADHD medication that have not yet been stabilized. • Treatment of patients with ADHD and substance misuse problems (e.g., Alcohol, misuse, solvents and other illicit drugs such as ecstasy and cannabis) • Treatment of patients with ADHD with complex mental health medication regimes i.e. severe depression / psychosis It is expected that excluded patients will be retained within specialist services **Please note: The provision of shared care prescribing guidelines does not necessarily mean that the GP must agree to and accept clinical and legal responsibility for prescribing; they should only do so if they feel clinically confident in managing that condition.** **Referral to the GP should only take place once the GP has agreed to this in each individual case, and the hospital or specialist will continue to provide prescriptions until a successful transfer of responsibilities has occurred. The GP should confirm the agreement and acceptance of the shared care prescribing arrangement and that supply arrangements have been finalised. The secondary/tertiary provider must supply an adequate amount of the medication to cover the transition period. The patient should then be informed to obtain**

	further prescriptions from the GP.
Background	• ADHD is a heterogeneous behavioral syndrome characterised by the core symptoms of hyperactivity, impulsivity and inattention. While these symptoms tend to cluster together, some people are predominantly hyperactive and impulsive, while others are principally inattentive. • Symptoms of ADHD are distributed throughout the population and vary in severity; only those with significant impairment meet criteria for a diagnosis of ADHD. • Symptoms of ADHD can overlap with symptoms of other related disorders therefore care in differential diagnosis is needed. • Diagnosis and initiation of treatment must be made by a specialist in the treatment of ADHD • Drug treatment, in line with the agreed treatment algorithm (Appendix A1), is the first line treatment for children and adolescents with ADHD with either moderate or severe levels of impairment. • Symptoms of ADHD become evident during childhood and patients are comprehensively assessed and diagnosed by specialists in the treatment of ADHD in children. For some young people with a sustained diagnosis, symptoms may persist into adulthood requiring treatment. This is addressed in NICE NG 87.
Secondary Care / Tertiary	1) Conduct pre-treatment assessments in line with NICE NG87 namely: • A full clinical and psychosocial assessment of the person; this should include discussion about behavior and symptoms in the different domains and settings of the person's everyday life **and** • A full developmental and psychiatric history **and** • Observer reports and assessment of the person's mental state • A full history and physical examination, including: ➢ A medical history, taking into account conditions that may be contraindications for specific medicines. ➢ Current medication ➢ Height and weight (measured and recorded against the normal range for age, height and sex) ➢ Baseline pulse and blood pressure (measured with appropriately sized cuff and compared with the normal range for age) ➢ A cardiovascular assessment ➢ An electrocardiogram (ECG) if the treatment may affect the QTc interval ➢ Referral for cardiology opinion if certain conditions apply. 2) Have a structured discussion with person/patient/their families or carers as appropriate about how ADHD could affect their life. 3) Signpost person/patient/their families or carers receiving a diagnosis of ADHD as appropriate about sources of information, including: local and national support groups and voluntary organisations, websites, support for education and employment. The information to be tailored to their individual needs and circumstances, including age, gender, educational level and life stage. 4) Ensure that people with ADHD have a comprehensive, holistic shared treatment plan that addresses psychological, behavioural and occupational or educational needs. 5) Record the person's preferences and concerns in their treatment plan. Patients should be able to decline shared care if, after due consideration of the options, they decide it is not in their best interests. Patients should provide explicit consent and this should be recorded in both the patients notes and on the shared care agreement form. 6) Initiate treatment in line with NICE NG 87 7) Provide information about the medication to patients, including common side effects, necessary monitoring, and where that monitoring will take place. Also, to keep the patient informed of the process at all stages to ensure continuity of treatment. 8) Titrate the dose against symptoms and adverse effects until dose optimisation is achieved, that is, reduced symptoms, positive behaviour change, improvements in education,

employment and relationships, with tolerable adverse effects as outlined in NG 87.

9) Continue all necessary physical health monitoring during the titration period and to monitor effectiveness of medication for ADHD and adverse effects, and document in the person's notes.

10) Prescribe and monitor the patient until a stable treatment dose is reached, usually a period of three months.

11) Continue to provide prescriptions until a successful transfer of responsibilities to the GP has occurred. The secondary/tertiary provider must supply an adequate amount of the medication to cover the transition period. With consent of the patient, Part 1 of the Shared Care Agreement Form must be signed, completed and forwarded in 2 weeks to the patients GP.

12) Once Part 2 of the Shared Care Agreement Form has been returned completed and signed by the patient's GP, the patient should then be advised to obtain further prescriptions from the GP after the transition period and must be made fully aware of all necessary monitoring requirements.

13) Ensure that patients receiving treatment for ADHD have review and follow-up according to the severity of their condition, regardless of whether or not they are taking medication.

14) Conduct an annual face to face medication review for all patients covered by this shared care guidance and consider discontinuation if the patient has been stable in the preceding year. Encourage people with ADHD to discuss any preferences to stop or change medication and to be involved in any decisions about stopping treatments. Inform GP of any decisions made, monitoring performed and results. CAMHS has a "was not brought" policy.

15) Contact the GP within 2 weeks should a patient miss a specialist face to face appointment to advise whether treatment should be withheld or if a dose change has been made to their medication.

16) Accept referrals back from primary care for medication discontinuation if the patient fails to engage with the GP or fails to attend their annual review with CAMHS.

17) Resume prescribing and monitoring of the patient when a decision for managed withdrawal of treatment has been taken.

18) Continue to provide emergency appointments where patients are receiving prescriptions from their GP if they feel that a prompt assessment or review of their ADHD treatment is required, e.g. new or worsening seizures, development of psychotic symptoms, suicidal thinking and self-harm of an urgent nature with atomoxetine or if diversion of medication is suspected with methylphenidate, dexamfetamine or lisdexamfetamine.

19) Provide prompt on-going advice to GP as required without necessarily requiring a new referral.

20) Provide advice to the GP as to the changes in parameters that should trigger urgent referral back to the specialist.

21) Telephone details and (if appropriate) secure email addresses for both Secondary/Tertiary and Primary Care should be exchanged and recorded. This should include out-of-hours contact numbers. Patients and their carers should also be provided with contact details for support and help if required; both in and out of hours.

22) CAMHS to have a clear written agreement with parents of their responsibilities and that if they fail to attend their children's medication reviews then the GP may not continue to prescribe their medication.

	In addition for children / adolescents 23) Give information about ADHD and offer additional support to parents and carers of all children aged 5 years and over and young people with ADHD. The support should be ADHD focused, can be group based and as few as 1 or 2 sessions. It should include: ➢ Education and information on the causes and impact of ADHD ➢ Advise on parenting strategies ➢ With consent, liaison with school, college or university (Both parents and carers if feasible 24) If a child aged 5 years or over or young person has ADHD and symptoms of oppositional defiant disorder or conduct disorder, offer parents and carers a parent-training programme in line with recommendations, as well as group-based ADHD-focused support. 25) Medication for children aged 5 years and over and young people should only be offered if: ➢ Their ADHD symptoms are still causing a persistent significant impairment in at least one domain after environmental modifications have been implemented and reviewed ➢ They and their parents and carers have discussed information about ADHD ➢ A baseline assessment has been carried out 26) A young person with ADHD receiving treatment and care from CAMHS or paediatric services should be reassessed at school-leaving age to establish the need for continuing treatment into adulthood. If treatment is necessary, arrangements should be made for a smooth transition to adult services with details of the anticipated treatment and services that the young person will require.
Primary Care Responsibilities	**Clinical responsibility for prescribing is held by the person signing the prescription, who must also ensure adequate monitoring.** 1) To consider requests to prescribe under shared care arrangements and reply in a timely manner by completing, signing and returning Part 2 of the Shared Care Agreement Form (Appendix D). 2) To provide continuation prescriptions or identify any concerns about the request to the prescriber in the specialist team. It is expected that primary care prescribers will not make changes to the dose/formulation, unless it is in consultation with the specialist team. 3) To monitor the patient in accordance with Appendix A and contact the specialist team if results give rise to concern. Any ongoing monitoring requirements for individual patients discharged from secondary/tertiary care will be identified by the specialist service as part of the discharge information to the GP. 4) To contact specialists within the team where concerns arise about a patient's presentation or when advice is needed, e.g. new or worsening seizures, development of psychotic symptoms, suicidal thinking and self-harm of an urgent nature with atomoxetine or if diversion of medication is suspected with methylphenidate, dexamfetamine or lisdexamfetamine. 5) To refer back to secondary/tertiary care if withdrawal of treatment might be indicated. This could be because: ➢ ADHD symptoms are not evident on days when medication is forgotten or missed ➢ There is evidence of misuse or diversion of ADHD medication ➢ There has been no need to increase the dose of medication in child or adolescent patients despite growth and weight gain over the preceding one to two years **Circumstances for discontinuation of treatment in Primary Care** 1) As a joint decision with specialist team providing specific advice in case of adverse effect pending assessment. 2) Following non-attendance at annual specialist team review pending that review taking pace or if there is failure to engage with the review process.

Primary Care Monitoring	• To undertake height , weight, BP and pulse if requested by specialist (Appendix C) • No biochemical or plasma drug level monitoring is required.

Dose and Administration

Licensed age	Starting dose	Increased by (if needed)	Max Daily dose	Comments
Methylphenidate – Immediate Release Generic tablets				
Child >6 years	5mg OD or BD (breakfast and lunch)	By 5-10mg weekly	60mg a day in two or three divided doses	Additional dose maybe needed later in day for children with rebound hyperactivity
Methylphenidate – Matoride XL , Xenidate XL, Xaggitin ® tablets				
Child >6 years	18 mg OD (morning)	Weekly by 18mg	54mg OD	15mg ordinary release is approx. equivalent to 18mg of Matoride XL, Xenidate, Xaggitin ® capsules
Methylphenidate – Medikinet XL capsules				
Child >6 years	10mg OD (am before breakfast)	Weekly intervals	60mg	Capsules may be opened and contents sprinkled on yogurt or apple sauce and swallowed without chewing
Atomoxetine generic tablets and liquid				
Child up to 70kg	0.5mg/kg a day for 7 days (morning)		1.2mg/Kg a day	No additional benefit seen in < 1.2mg/kg a day
Child > 70Kg	40mg a day for 7 days (morning)		100mg a day (morning)	Licensed up to 100mg but no additional benefit >80mg
Dexamfetamine generic tablets and oral solution				
Child 3-5 years	2.5mg OD	2.5mg each week		
Child > 6 years	2.5mg BD or TDS a day	5mg each week	20mg	Occasionally up to 40mg
Lisdexamfetamine generic tablets				
Child > 6 years	30mg OD	20mg at least weekly intervals	70mg OD	Quick action so some parents just use on school days
Guanfacine tablets				
Child 6-12yrs Body wt = >25kg	1mg OD	1mg per week	4mg (0.05 – 0.12kg/kg)	Maintenance dose
Child 13-17 years Body wt = 34-	1mg	1mg per week	4mg (0.05 – 0.12kg/kg)	Maintenance dose

	41.4kg				
	Child 13-17 Body wt = 41.4-49.4 kg	1mg OD	1mg per week	5mg (0.05 – 0.12kg/kg)	Maintenance dose
	Child 13-17 years Body wt = 49.5-58.4kg	1mg	1mg per week	6mg (0.05 – 0.12kg/kg)	Maintenance dose
	Child 13-17 years Body wt = >58.5kg	1mg	1mg per week	7mg (0.05 – 0.12kg/kg)	Maintenance dose

Important adverse effects and management

Common side effects	Drugs associated	Lasting effects	Actions
Nausea & vomiting	Methylphenidate Atomoxetine	Usually transient	Stop using if persists for longer than a few days or becomes untenable
Drowsiness, Headache, Effects on vision	Methylphenidate Dexamfetamine Lisdexamfetamine	Usually transient	Stop drug if persists for longer than a few days or becomes untenable
Insomnia	Lisdexamfetamine Dexamfetamine Methylphenidate	Usually poor settling, especially in a child who was a poor sleeper before. May be transient	If not transient: Move the evening dose to 6pm first / or try reducing the 4pm dose.
Somnolence	Atomoxetine	Usually transient, occurs early in therapy. May be helped by taking dose with food to slow rate of absorption	Be sure to distinguish between somnolence and reduction in ADHD symptoms. Usually transient but can continue for some weeks. Stop drug if becomes untenable
Early morning wakening	Atomoxetine	Usually transient	Stop drug if persists for longer than a few days or becomes untenable
Abdominal pain	Atomoxetine	Usually transient – may be more common with BD dosing	Stop drug if persists for longer than a few days or becomes untenable
Irritability & mood swings	Atomoxetine		If problematic contact monitoring consultant for further advice
Poor appetite	Lisdexamfetamine Dexamfetamine Methylphenidate Atomoxetine**	Usually transient. If persists, usually in children who have always been fussy eaters	Give the drug after the meal. Make sure the child eats a lot at night when medication has worn off. Monitor height and weight. If child has moved down through a centile refer to specialist for advice about dose adjustment / stopping therapy.

	Anxiety; appetite decreased; arrhythmias; asthenia; constipation; depression; diarrhoea; dizziness; drowsiness; dry mouth; gastrointestinal discomfort; headache; hypotension; mood altered; nausea; skin reactions; sleep disorders; urinary disorders; vomiting; weight increased	Guanfacine		Manufacturer advises avoid administration with high fat meals (may increase absorption). Manufacturer advises that patients and carers should inform their prescriber if more than one dose is missed; consider dose re-titration
Important Drug interactions	**Methylphenidate** • May inhibit the metabolism of coumarin anticoagulants, some anticonvulsants, phenylbutazone and tricyclic antidepressants. The dosage of these drugs may need to be reduced • Should not be used with MAOI's nor initiated within two weeks of cessation of treatment with an MAOI as may precipitate a hypertensive crisis • Caution with pressor agents **Dexamfetamine/lisdexamfetamine** • Should not be used with MAOI's nor initiated within two weeks of cessation of treatment with an MAOI as may precipitate a hypertensive crisis • Adrenoreceptor blocking agents e.g. propranolol, lithium and α methyltyrosine may antagonise the effects of dexamfetamine. Concurrent use with beta blockers may precipitate a hypertensive crisis • Use with tricyclic antidepressants may increase risk of cardiovascular side effects • Acute dystonias have been noted with concurrent administration of haloperidol • Phenothiazines may inhibit the actions of dexamfetamine • Dexamfetamine may inhibit the absorption of ethosuximide, phenobarbital and Phenytoin **Atomoxetine** • Atomoxetine can be used initially in combination with stimulant medications, whilst waiting for sufficient clinical effect of the atomoxetine to commence. Once sufficient clinical effect of atomoxetine has been established the stimulant medication should be discontinued due to clinical evidence of potential additive risk of blood pressure elevation. • Caution with pressor agents or drugs affecting noradrenaline, e.g. venlafaxine, mirtazapine • Should not be used with MAOI's nor initiated within two weeks of cessation of treatment with an MAOI as may precipitate a hypertensive crisis. • Caution with drugs that can prolong the QT interval, e.g. anti-arrhythmics, erythromycin, tricyclic antidepressants, antipsychotics, lithium, etc. • Caution in patients on high dose nebulised/systemic salbutamol. • Caution with drugs which lower the convulsive threshold e.g. antipsychotics **Guanfacine** • **CYP3A4 inducers** (e.g. bosentan, carbamazepine, efavirenz, etravirine, modafinil, nevirapine, oxcarbazepine, phenobarbital, phenytoin, primidone, rifabutin, rifampicin, St John's Wort.) - Plasma concentration of guanfacine reduced. • **CYP3A4/5 inhibitors** (ketoconazole, boceprevir, clarithromycin, erythromycin, indinavir, itraconazole, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin) - Plasma concentration of guanfacine increased • **Antihypertensive medicines** – risk of hypotension / syncope • **Valproic Acid** - can result in increased concentrations of valproic acid with potential			
Dose and administration	**Guanfacine (Intuniv ®): Prolonged Release Tablets 1mg, 2mg, 3mg ,4mg** **Child 6-17 years:**			

The recommended starting dose is 1 mg, taken orally once a day. The dose may be adjusted in increments of not more than 1 mg per week. Dose should be individualised according to the patient's response and tolerability.

The recommended maintenance dose range is 0.05-0.12 mg/kg/day

The recommended dose titration for children and adolescents is provided below. Dose adjustments (increase or decrease) to a maximum tolerated dose within the recommended optimal weight-adjusted dose range based upon clinical judgement of response and tolerability may occur at any weekly interval after the initial dose.

Dose Titration Schedule for Children Aged 6-12 years

Weight group	Week 1	Week 2	Week 3	Week 4
25kg and up Max dose = 4mg	1mg	2mg	3mg	4mg

Dose Titration Schedule for Adolescents Aged 13-17 Years

Weight group	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7
34-41.4Kg Max dose =5mg	1mg	2mg	3mg	4mg			
41.4-49.4Kg Max dose =5mg	1mg	2mg	3mg	4mg	5mg		
49.5-58.4Kg Max dose 6mg	1mg	2mg	3mg	4mg	5mg	6mg	
58.5mg and above Max dose = 7mg	1mg	2mg	3mg	4mg	5mg	6mg	7mg

a) Adolescent subjects must weigh at least 34 kg.

b) Adolescents weighing 58.5 kg and above may be titrated to a 7 mg/day dose after the subject has completed a minimum of 1 week of therapy on a 6 mg/day dose and the physician has performed a thorough review of the subject's tolerability and efficacy. Patients/caregivers should be instructed not to discontinue guanfacine without consulting their physician. When stopping Guanfacine, the dose must be tapered with decrements of no more than 1 mg every 3 to 7 days, and blood pressure and pulse should be monitored in order to minimise potential withdrawal effects, in particular increases in blood pressure and heart rate.

N.B Missed dose
In the event of a missed dose, guanfacine dosing can resume the next day. If two or more consecutive doses are missed, re-titration is recommended based on the patient's tolerability to guanfacine. If the patient needs re-titration then this should be undertaken by secondary care.

Appendix A: Monitoring Requirements for GPs under ADHD shared care agreement

Baseline/initial monitoring until the patient is on a stable dose will be carried out by secondary care provider. Monitor effectiveness of medication and adverse effects, document in the person's notes

Monitoring Required	Methylphenidate	Dexamfetamine	Lisdexamfetamine	Atomoxetine	Guanfacine
Cardiac function and blood pressure • Ensure heart rate / pulse and blood pressure are monitored at each dose adjustment and at least every 6 months (3months for guanfacine) • Sustained resting tachycardia (>120bpm), arrhythmia or systolic blood pressure greater than the 95th percentile (or a clinically significant increase) should prompt referral to the secondary care provider) **An ECG is only required at baseline if there is a clinical indication**	✓	✓	✓	✓	✓ Every 3 months Signs of bradycardia and hypotension should prompt referral to the specialist service for those receiving guanfacine
Weight, Height and Appetite * Adult • Ensure weight is monitored at each dose adjustment and at least every 6 months **Children and young people** • Measure height every 6 months in children and young people • Measure weight every 3 months in children 10 years and under • Measure weight at 3 and 6 months after starting treatment in children over 10 years and young people, and every 6 months thereafter, or more often if concerns arise. **For Guanfacine** • BMI should be done every 3 months for the first year and then 6 monthly thereafter.	✓	✓	✓	✓	✓
New or worsening psychiatric symptoms • Monitor at each dose adjustment and at least every 6 months	✓	✓	✓	✓	✓
Onset or exacerbation of motor and verbal tics** • Monitor at each dose adjustment and at least every 6 months	✓	✓	✓	✓	N/A
Somnolence / Sedation	N/A	N/A	N/A	N/A	Every 3 months
Sexual Dysfunction	N/A	N/A	N/A	N/A	N/A
Sleep Pattern (e.g. sleep diary)	✓	✓	✓	✓	✓

* Strategies to reduce weight loss include:
  - Taking medication either with or after food, rather than before meals
  - Eating additional meals or snacks early morning or late evening when stimulant effects have worn off
  - Obtaining dietary advice and eating high-calorie foods of good nutritional value.

** If tics are stimulant related, reduce the stimulant dose, or consider changing to guanfacine (in children aged 5 years and over and young people only), atomoxetine, clonidine (clonidine does not have a UK marketing authorisation for this indication), or stopping medication

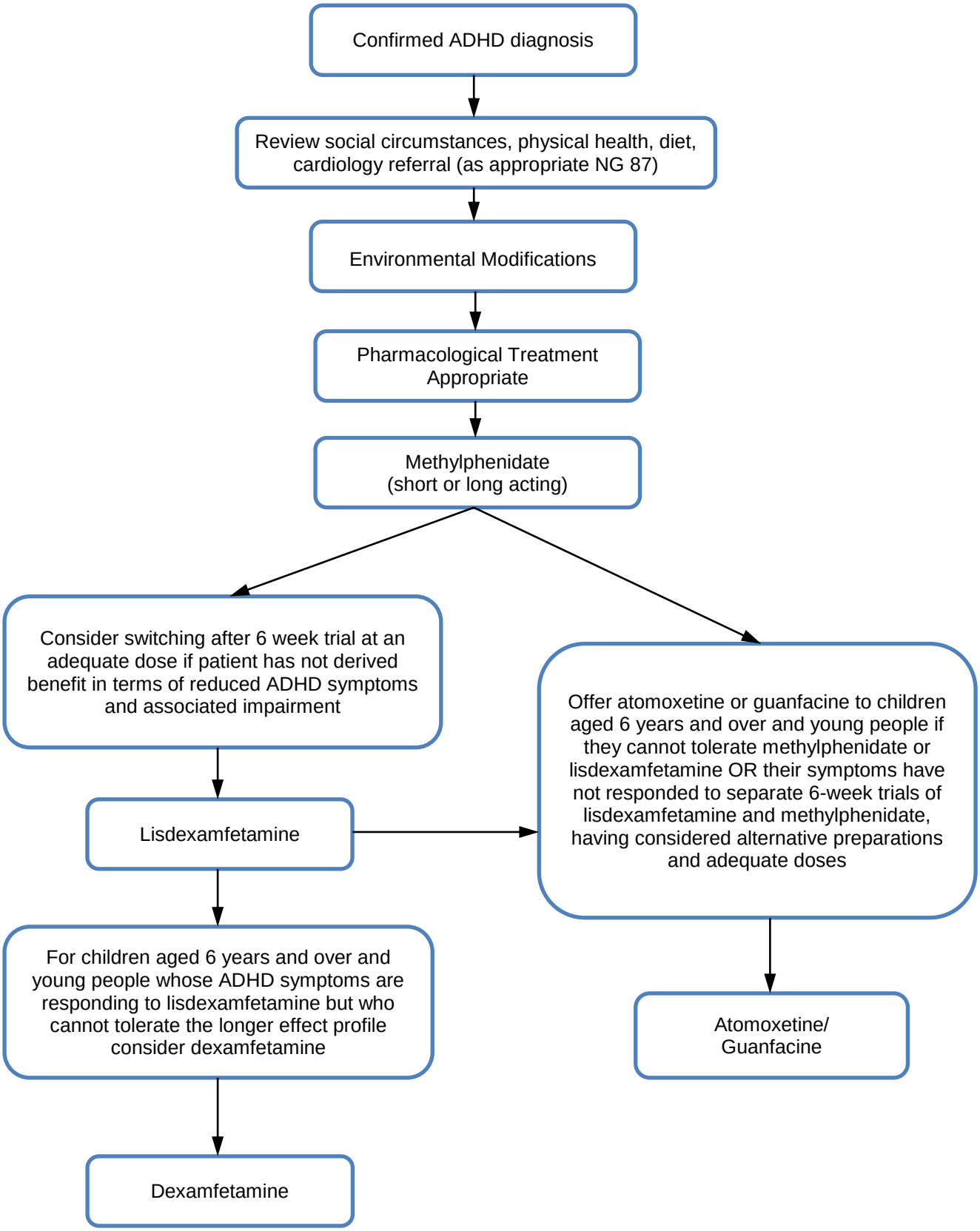
Monitoring Required only in response to symptoms	Methylphenidate	Dexamfetamine	Lisdexamfetamine	Atomoxetine	Guanfacine
Blood tests for liver function • If abdominal pain, unexplained nausea, jaundice, darkened urine or malaise. • If an adverse effect is suspected the secondary care provider should be contacted for advice and an urgent assessment • GP to copy in specialist to any blood tests undertaken	N/A	N/A	N/A	✓	✓
Cardiac evaluation • If develop symptoms such as exertional chest pain, unexplained syncope, or other symptoms suggestive of cardiac disease during treatment.	✓	✓	✓	✓	✓
BMI • If there has been a weight change as a result of their treatment	✓	✓	✓	✓	✓
New or worsening seizures • GP to contact specialist immediately for review of treatment.	✓	✓	✓	✓	N/A

Patients should be monitored for the risk of diversion, misuse, and abuse of methylphenidate, dexamfetamine and lisdexamfetamine

Annual face to face medication review by the secondary care provider

Medication review	Methylphenidate	Dexamfetamine	Lisdexamfetamine	Atomoxetine	Guanfacine
An annual medication review to assess the patient for ongoing treatment. • Carried out by the secondary care provider and to also include all physical monitoring. • Stop ADHD medication - suspend shared care until reviewed by specialist team	✓	✓	✓	✓	✓

Appendix A1: Pharmacological Treatment Algorithm - ADHD in Children aged 6 -18 years (NG 87)



Appendix B: Shared Care Agreement

Southampton City Clinical Commissioning Group

Solent NHS Trust

Shared Care Prescribing Guideline

Licensed Medications for the Treatment of Attention Deficit Hyperactivity Disorder (ADHD) in Childhood

Agreement for transfer of prescribing to GP

Patient details / addressograph:

Patient ID Label:
Surname:
Forename:
Address
Date of Birth:
NHS Number:

Drug name and dose:

The following tests, investigations have been carried out:

Blood pressure:	Date:
Pulse:	Date:
Weight (including centiles):	Date:
Height (including centiles):	Date:
Diagnosis of ADHD made on	Date:
Patient stabilised on (drug/dose):	
Patient's last clinic visit on (date):	Date:
Patient next clinic visit on:	then every 12 months

Consultant: Address: Contact Number: Email:	**Agreement to shared care, to be signed by GP, Consultant and carer.** Consultant Signature: Date:
GP: Address: Contact Number: Email:	GP Signature: Date:
Main Carer: Address: Contact Number:	Main Carer: Date:
Key worker if appropriate: Contact Number:	

If shared care is agreed and GP has signed above please return a copy of this page to the requesting consultant

ADHD Shared Care Protocol Follow Up Sheet – 12 monthly physical medication review monitoring

Patient name/ Date of Birth **NHS Number/ Hospital number**		**GP Practice / email address**	
Height (cm)	**Weight (kg)**	**Pulse**	**BP**
Previous: Date: Current: Date:	Previous: Date: Current: Date:	Previous: Date: Current: Date:	Previous: Date: Current: Date:
Appetite (please circle)	Good	Moderate	Poor
Medication (name/s and current dosage)			
Does this child require an early review at the Behavioural Clinic (Planned review 12 monthly)	Yes / No If Yes - Why		

Appendix C: Monitoring of Height, Weight and Pulse in Primary Care

As per Nice guidelines 2018

1. Monitor effectiveness of medication for ADHD and adverse effects, and document in the person's notes. [2018] 1.8.2

For people taking medication for ADHD:

- measure height every 6 months in children and young people
- measure weight every 3 months in children 10 years and under
- measure weight at 3 and 6 months after starting treatment in children over 10 years and young people, and every 6 months thereafter, or more often if concerns arise
- measure weight every 6 months in adults
- plot height and weight of children and young people on a growth chart and ensure review by the healthcare professional responsible for treatment. [2018]

Appendix D: APLS Normal Values

APLS normal values

Normal ranges: respiratory rate (RR), heart rate (HR) and blood pressue (BP)							
	Guide weight (kg)		**RR At rest Breaths per minute 5th–95th centile**	**HR Beats per minute 5th–95th centile**	**BP Systolic**		
Age	**Boys**	**Girls**			**5th centile**	**50th centile**	**95th centile**
Birth	3.5	3.5	25–50	120–170	65–75	80–90	105
1 month	4.5	4.5					
3 months	6.5	6	25–45	115–160			
6 months	8	7	20–40	110–160			
12 months	9.5	9			70–75	85–95	
18 months	11	10	20–35	100–155			
2 years	12	12	20–30	100–150	70–80	85–100	110
3 years	14	14		90–140			
4 years	16	16		80–135			
5 years	18	18			80–90	90–110	111–120
6 years	21	20		80–130			
7 years	23	22					
8 years	25	25	15–25	70–120			
9 years	28	28					
10 years	31	32					
11 years	35	35					
12 years	43	43	12–24	65–115	90–105	100–120	125–140
14 years	50	50		60–110			
Adult	70	70					