**HAMPSHIRE, PORTSMOUTH & SOUTHAMPTON**

Adult ADHD Referral Form

## The Adult ADHD Service accepts referrals for patients in the Hampshire area for the purpose of ADHD assessment, diagnosis and treatment. If a patient has other neurodevelopmental or mental health needs, these must be managed separately and referred to the appropriate service.

**The referral must be completed in full.** If information is missing, the referral will be returned, and the patient will not be added to our waiting list. **No other screening tool is required for this ADHD referral.**

**Please send completed forms to:** **adhd.phl@nhs.net**

# Patient details

Name .................................................................................................................................................................................................................................................................................................................

Gender .................................................... DOB ............................................................... NHS Nº .......................................................................................................................................................

Address ...........................................................................................................................................................................................................................................................................................................

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Phone Nº ..................................................................................................................................Email .......................................................................................................................................................

**Is the patient aware of the referral?** Yes  No 

**Has the patient consented to the referral?** Yes  No 

**Is the patient aware that there are extended waiting times at present?** Yes  No 

# GP details

Name .................................................................................................................................................................................................................................................................................................................

Practice............................................................................................................................................................................................................................................................................................................

Phone Nº .................................................................................................................................. Email .......................................................................................................................................................

**Referrer details** *if different to GP*

Name .................................................................................................................................................................................................................................................................................................................

Organisation ................................................................................................................................................................................................................................................................................................

Job title ............................................................................................................................................................................................................................................................................................................

Phone Nº .................................................................................................................................. Email .......................................................................................................................................................

Address ...........................................................................................................................................................................................................................................................................................................

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**Date of referral** ...............................................................................................................................

**Reason for referral** *please select* **ONE**

**NEW** ADHD diagnostic assessment *Patient has not been assessed for ADHD before*

## **EXISTING** ADHD diagnosis requiring initiation/titration of ADHD medication

### Patient has never been treated for ADHD

**RESTART** of ADHD medication

### Patient has been treated for ADHD in the past but is not currently on treatment

**REVIEW** of ADHD medication

### Patient is currently on ADHD treatment under shared care which needs adjusting

ADHD medication review **TO SUPPORT SHARED CARE ARRANGEMENTS**

### Patient is on ADHD treatment, but needs review to facilitate shared care

***Please complete Sections:***

 **A B D**

 **A B C**

 **A B C**

 **A B C**

 **A B C**

# Supporting information

 **SECTION A** Why is the patient being referred? What are their expectations?

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 **SECTION B** Risk assessment

**Is there current or past risk of harm to self or others?** Yes  No 

**Are there any safeguarding concerns?** Yes  No 

**Details:** .............................................................................................................................................................................................................................................................................................................

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**Supporting information** *clinical summary can be attached separately if easier*

**Past medical & psychiatric history**......................................................................................................................................................................................................................................

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**Medication** *including dose & frequency*.........................................................................................................................................................................................................................

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**Allergies**..........................................................................................................................................................................................................................................................................................................

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**Details of any health, social care or education services involved** *please attach any reports which may be relevant*

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 **SECTION C For medication-related referrals Observations** *within the last three months*

|  |  |  |  |
| --- | --- | --- | --- |
| **BP** | **HR** | **Height** | **Weight** |

**Supporting documents required:**

**A:** Copy of ADHD diagnostic report (if not diagnosed by PHL) **B:** Copy of last ADHD clinic letter (if not provided by PHL)

 **SECTION D**

**Examples of inattentive symptoms causing difficulty** *if applicable*

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**Examples of hyperactive symptoms causing difficulty** *if applicable*

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**Examples of impulsive symptoms causing difficulty** *if applicable*

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**At what age did the symptoms start?**......................................................................

**Have these symptoms persisted since childhood and throughout adulthood?** Yes  No  N/A: Adult Onset 

**Which areas have been affected?** *Please select as many as applicable*

**Family ** **Work ** **Education ** **Life skills ** **Self-concept ** **Social ** **Risk ** **Please provide additional information** *if applicable*

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