ADHD going care clinic referral form

Please complete all sections. Incomplete sections will not be processed and will result in a return to the referring doctor. All referrals must be signed by the referring doctor and must be accompanied by a clinic stamp on the referral form.

The deadline for receipt of completed forms for consideration for 1st semester clinic is October 1st.

The deadline for receipt of completed forms for consideration for 2nd semester clinic is March 1st.

Name of patient	
DOB	
Address	
Health insurance details: Health insurance number Ireland	Yes □ No □ VHI □ AVIVA □ LAYA □
Next of Kin Name: Name of person to provide collateral if required	
Name and Address of Referring Psychiatrist	

Date diagnosis made:	
Actual diagnosis:	ADD □ ADHD□
Diagnostic tools used to establish diagnosis	Connors □ DIVA □ CADDRA □ Other: please state_____ Please note that screening tools such as the ASRS are not sufficient to establish a diagnosis
Evidence of Impairment prior to the age of 12 Evidence of Impairment prior to the age of 12 established through:	Yes □ School reports □ Collateral history □ Other: please state_____
Comorbid diagnosis	ASD □ Dyspraxia □ Dyslexia □ Generalized anxiety disorder □ Panic Disorder □ OCD □ Anorexia Nervosa Bulimia Nervosa □ Binge Eating Disorder □ Psychosis □ Other
Risk Assessment	Current deliberate self harm □ History of deliberate self harm □ Current Suicide ideation □ History of suicide ideation □
Previous inpatient admission details	Yes □ No □
Current alcohol intake	_____ units a week

<table>
<tr><td>Cannabis intake</td><td>Frequency per week ____</td></tr>
<tr><td>Current Medication and dose

Previous Medication and reasons for discontinuation</td><td>Ritalin □
Concerta □
Ritalin LA □
Tyvense □
Other:

_____</td></tr>
<tr><td>Medication Allergy</td><td></td></tr>
<tr><td>Family Psychiatric History</td><td>ADHD □
Neurodevelopmental disorder: □
ASD □
Mood disorder□
Addiction □
BPAD □</td></tr>
<tr><td>Patient will require ECG if a history of the following</td><td>History of congenital heart disease or previous cardiac surgery: Yes □ No □
History of SADS in first degree relatives under 40: Yes □ No □
SOB on exertion compared to peers: Yes □ No □
Faiting on exertion or in response to fright or noise: Yes □ No □e
Palpitations: Yes □ No □
Chest pain or cardiac origin: Yes □ No □
Signs of heart failure: Yes □ No □</td></tr>
<tr><td>Personal or Family Medical History</td><td><table><tr><td></td><td>Personal</td><td>Family</td></tr><tr><td>Hypertension</td><td></td><td></td></tr><tr><td>Tachycardia</td><td></td><td></td></tr><tr><td>Arrhythmia</td><td></td><td></td></tr><tr><td>Dyspnoea on exertion</td><td></td><td></td></tr><tr><td>Fainting</td><td></td><td></td></tr><tr><td>Chest pain on exertion</td><td></td><td></td></tr><tr><td>SADS</td><td></td><td></td></tr></table></td></tr>
<tr><td>Physical examination completed</td><td>Yes □ No □
Findings □</td></tr>
<tr><td>BP _____ Pulse_____</td><td>Weight _____ Height_____</td></tr>
<tr><td>Date that the patient was last assessed and ongoing care need established</td><td></td></tr>
<tr><td>I have established and recommend an ongoing care need
I understand that clinical care for ADHD management will remain with me until the patient has transferred care to another consultant psychiatrist</td><td>Signed:

Signed:

Stamp of Care Provider:</td></tr>
</table>