**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 |

|  |  |
| --- | --- |
| Cannabis intake | Frequency per week \_\_\_\_ |
| Current Medication and dose  Previous Medication and reasons for discontinuation | Ritalin □  Concerta □  Ritalin LA □  Tyvense □  Other:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medication Allergy |  |
| Family Psychiatric History | ADHD □  Neurodevelopmental disorder: □  ASD □  Mood disorder□  Addiction □  BPAD □ |
| Patient will require ECG if a history of the following | 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 □ |
| Personal or Family Medical History | |  |  |  | | --- | --- | --- | |  | Personal | Family | | Hypertension |  |  | | Tachycardia |  |  | | Arrhythmia |  |  | | Dyspnoea on exertion |  |  | | Fainting |  |  | | Chest pain on exertion |  |  | | SADS |  |  | |
| Physical examination completed | Yes □ No □  Findings □ |
| BP \_\_\_\_\_\_\_\_\_\_\_\_ Pulse\_\_\_\_\_\_\_\_\_\_\_\_\_ | Weight \_\_\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date that the patient was last assessed and ongoing care need established |  |
| 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 | Signed:  Signed:  Stamp of Care Provider: |