**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 | Depression □ASD □Dyspraxia □Dyslexia □Generalized anxiety disorder □Panic Disorder □OCD □Anorexia NervosaBulimia Nervosa □Binge Eating Disorder □Psychosis □Bipolar Affective Disorder □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  | Ritalin □Concerta □Ritalin LA □Tyvense □Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Current dose |    |
| Previous medication and reasons for discontinuation |  |
| Other prescribed medications with doses |  |
| Medication Allergy |  |
| Family Psychiatric History  | ADHD □Neurodevelopmental disorder: □ASD □Depression □Anxiety □Addiction □BPAD □ |
| Patient will require ECG if a history of the following |

|  |  |  |
| --- | --- | --- |
| **Cardiovascular risk** | **YES** | **NO** |
| History of congenital heart disease or previous cardiac surgery |  |  |
| History of SADS in first degree relatives under 40 |  |  |
| SOB on exertion compared to peers |  |  |
| Fainting on exertion or in response to fright or noise |  |  |
| Palpitations |  |  |
| Chest pain or cardiac origin |  |  |
| Signs of heart failure |  |  |

 |
| Personal or Family Medical History  |

|  |  |  |
| --- | --- | --- |
|  | Personal | Family |
| Hypertension |  |  |
| Tachycardia |  |  |
| Arrhythmia |  |  |
| Dyspnoea on exertion |  |  |
| Fainting |  |  |
| Chest pain on exertion |  |  |
| SADS |  |  |

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| Physical examination completed  | Yes □ No □Findings □ |
| Vital signs and BMI (**must be monitored by healthcare professional** - self reported/ monitored not accepted) | Date monitored:Blood pressure:Heartrate:Height:Weight:BMI: |
| Date that the patient was last assessed and ongoing care need established  |  |
| I have established and recommend an ongoing care needI 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: |