

Adult ADHD Assessment Referral Form

Please send completed form plus supporting documents to chosen provider as detailed below:

IMPORTANT – Choice of Provider:

Which is the chosen provider to refer to?

☒ **Harrow Health CIC:** NW London Accredited ADHD Provider – Send via ERS (preferred)

Accredited providers have been quality assured and evidenced that service provision will be in line with the NW London ICB Adult ADHD assessment and treatment service specification including a commitment to shared care with GPs.

Please note **other** NHS Right to Choose providers may not offer titration and medication and this will need to be made clear to the patient.

- ✓ Please ensure that all clinical information required in Section 8 is submitted together with the Referral form, together with any relevant reports. Failure to do so will result in delays for your patient.
- ✓ Please note that the patient will be discharged back to the GP once stabilised on medication we are not commissioned to provide annual reviews, these will be undertaken in primary care

1. PATIENT DETAILS		2. REFERRER DETAILS	
Name		Date of Referral	
DOB		Name of Referrer	
NHS No.		Role of Referrer (if not GP)	
Address		Name of GP (if not referrer)	
Mobile		GP Surgery	
Home phone		Address	
Email		Borough of NWL	
Gender		GP Telephone	
Ethnicity		GP Practice Email (NHSmail)	
Disabilities/Reasonable Adjustments required		Bypass number for queries	Use NHS Service Finder to access Bypass number.
Interpreter needed?	☐ Yes ☐ No		
Main Language spoken	Main spoken language English		

3. REASONS FOR REFERRAL

Please summarise: symptoms the patient is experiencing suggestive of ADHD / other; how day to day living is affected, and any co-morbid mental health or neurodevelopmental conditions or substance misuse:

ADHD Diagnosis previously made?	☐ Yes - Details:	☐ No
Patient currently on ADHD medication?	☐ Yes - Details:	☐ No

Patient open to a mental health service?	☐ Yes - Which service? <i>NB if 'yes' is selected, ADHD referral should be made to CNWL so that they can liaise with this mental health service</i> ☐ No:
Does patient have history of contact with CAMHS?	☐ Yes- Details: ☐ No
Has the patient consented to this referral?	☐ Yes ☐ No - Details why not:
4. GOAL(S) OF REFERRAL – please consider both assessment and potential ongoing treatment.	
<i>Please include patient opinion and expectation:</i>	
5. SUMMARY OF RISK – please include suicide, self-harm and harm towards others.	
☐ Suicide	☐ Safeguarding
☐ Self harm/ Risk taking behaviours	☐ Risk to others/ violent behaviour/ forensic history?
☐ Self neglect	☐ Alcohol/Substance misuse (with primary MH need):
Details/ other:	
Current/previous history of domestic abuse/violence?	☐ Yes ☐ No
Any children (living with patient) aged under 18 years?	☐ Yes ☐ No
Currently pregnant or up to 2 years post-partum?	☐ Yes ☐ No
Subject to Leaving Care provisions?	☐ Yes ☐ No
6. RELEVANT MEDICAL, PSYCHIATRIC OR FORENSIC HISTORY	
Please confirm you will share patient records data with the provider (subject to data sharing agreement) ☐ Yes ☐ No	

7. MEDICATIONS & ALLERGIES		
Past Mental Health Medication - Please provide details of any past medication which might not have been effective or tolerated:		
Acute Medication in the last 1 month		
Start date	Drug name	Dose
Repeat Medication		
Drug name	Dose	Last issued

Allergies & Sensitivities

Start date	Allergy (no Read Code) or Sensitivity	Details

8. REQUIRED CLINICAL INFORMATION

Test	Result	Date
BP		
Pulse		
BMI		
Blood results: FBC, U&E, blood sugar, serum creatine, LFTs, TFTs	Please attach if not merged below	
ECG	Please attach	

Blood Results

TEST	RESULT	DATE
Full Blood Count		
Haemoglobin concentration		
Total White Blood Count		
Mean Cell Volume		
Platelet Count		
Reactive Protein		
U&E		
GFR Calculated		
Serum Creatinine Level		
Serum Sodium Level		
Serum Potassium Level		

Liver Function Tests

Serum alanine aminotransferase level (ALT)		
Serum alkaline phosphatase level (ALP)		
Serum Bilirubin level		
Gamma-glutamyl transferase level (GGT)		
Aspartate transaminase (AST)		
Serum Albumin level:		

Thyroid Function Tests		
Serum TSH level (depending on symptoms)		
Serum T4 level (depending on symptoms)		

ECG		
Electrocardiogram		