Referral to the ADHD Service

Part 2 – to be completed by the patient/family
Please attach to Part 1 and send with referrer information

Patient Information	
Full name:	
Date of Birth:	
NHS number (if known):	
Address:	
Contact number:	
Email address:	

Developmental History – did you have any of the following?					
Pregnancy Complications	☐	Delay / Accelerated Developmental Milestones	☐	Behavioural Issues	☐
Birth Complications	☐	Settling/Sleep Problems	☐	Sensory Processing Difficulties	☐
		Feeding/Eating Problems	☐	Social interaction Issues	☐
If Yes to any, please describe problem and any investigations and treatment					
Any Developmental Diagnoses? *i.e. autism, specific learning difficulty, learning disability etc.*					
Any Childhood adverse events? *i.e. trauma, abuse, parental mental health problems, parental substance abuse etc.*					
Family History					
Any known family history of ADHD?					

Please give details of familial relationship and diagnosis			
Any known family history of the following? *i.e. autism, specific learning difficulty, learning disability, dyslexia, dyspraxia, dyscalculia,* *anxiety, depression, OCD, Tourette, psychosis, alcohol or substance use problem, genetic disorder, cardiovascular problems*			
Educational/Work History			
Currently in Education?	School / College☐	Higher Education☐	No☐
Please give details of the schools attended and any problems in school /education School reports available Yes ☐ No ☐			
Currently working?	Employed☐	Self-employed☐	Not in work☐
Please give details of any problems in work/employment?	Peers / Colleagues: Managers: Time Management:		
Preferred type of work			
Sleep, Drug and Alcohol History			
Any sleep issues? *How many hours of sleep on average in past 4 weeks?* *How often daytime nap in a week?* *Bedtime?* *How long does it take to fall asleep?* *Sleep more often broken or solid?* *Waking up time?*			

Morning or evening type?	
Current weekly alcohol intake (units per week, on average)	
Current cannabis use (on average per week)	
Use of other recreational substances, in particular stimulant drugs e.g. Cocaine, Amphetamines, MDMA etc	Effect: Current usage: Past usage:
Current caffeine intake (coffee, energy drinks etc)	
Current Nicotine intake (cigarettes and vaping)?	

Main Concerns		
What are your main concerns? *i.e. inattention, hyper-activity, impulsivity*		
What is the impact of the issues on these areas of your life?	Education/Employment	
	Personal/Social relationships	
	Self-concept/ view of self	
	Other	
Childhood Symptoms of ADHD (before the age of 12)	Impact on school /learning problems	
	Impact on Family/ Parental/ Friendships	
	Risk taking/ Accidents	
	General Behaviour	

ASRS

Please answer the question below, rating yourself on each of the criteria shown using the scale on the right hand side of the page. As you answer each question, please place an X in the best that best described how you have felt and conducted yourself over the past 6 months

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once that challenging parts have been done?	☐	☐	☐	☐	☐

	Never	Rarely	Sometimes	Often	Very Often
2. How often do you have difficulty getting things in order when you have to do a task that requires organisation?	☐	☐	☐	☐	☐
3. How often do you have problems remembering appointments or obligations?	☐	☐	☐	☐	☐
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	☐	☐	☐	☐	☐
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	☐	☐	☐	☐	☐
6. How often do you feel overly active and compelled to do things, like you are driven by a motor?	☐	☐	☐	☐	☐
7. How often do you make careless mistakes when you have to work on a boring or difficult project?	☐	☐	☐	☐	☐
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	☐	☐	☐	☐	☐
9. How often do you have difficulty concentrating on what people say to you even when they are speaking to you directly?	☐	☐	☐	☐	☐
10. How often do you misplace or have difficulty finding things at home or at work?	☐	☐	☐	☐	☐
11. How often are you distracted by activity or noise around you?	☐	☐	☐	☐	☐
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	☐	☐	☐	☐	☐
13. How often do you feel restless or fidgety?	☐	☐	☐	☐	☐
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?	☐	☐	☐	☐	☐
15. How often do you find yourself talking too much when you are in social situations?	☐	☐	☐	☐	☐
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	☐	☐	☐	☐	☐
17. How often do you have difficulty waiting your turn in situations when your turn is required?	☐	☐	☐	☐	☐
18. How often do you interrupt others when they are busy?	☐	☐	☐	☐	☐