RDASH ADHD Services Referral Form

Please note that this referral form can be completed by the patient, professional or by someone supporting the patient with their consent.

Date of Referral	
Patient Name	
Patient's Preferred Name	
Patient's Preferred Pronouns	
NHS Number (If known)	
Date of Birth:	
Contact Details (Address and Telephone)	
Patient email address:	
Best way to contact patient:	
Registered GP details (if not referrer)	

If not patient:

Referrer Name, Occupation, Team & Contact Details	
Does the patient consent to the referral being made?	**Yes** ☐ **No** ☐

Reason for referral	Medication treatment for existing diagnosis of ADHD ☐ – Please complete Section A and C ADHD Diagnostic Assessment ☐ – Please complete Section B and C

Referrers, please ask the patient the following questions

Section A - Medication Treatment (please only fill in this section if you/the patient has an existing diagnosis of ADHD)

When and where did you receive a diagnosis of ADHD?	**Private/Self- Paid for ☐** **NHS Right to Choose ☐** **Please state the company name:**
Are you currently taking ADHD medication?	**Yes ☐ No ☐** ***If yes, please give more information and about why you are seeking medication support…..***
Have you got a copy of the diagnostic report/written evidence of your ADHD diagnosis? *(Please include this documentation with the referral)*	**Yes ☐ No ☐**

Section B - Diagnostic Assessment for ADHD (please only fill in section B if you/the patient does not have a diagnosis of ADHD already)

Referrers, please ask the patient the following questions

ADHD symptoms

(Please note that by not providing evidence in the following areas this could lead to your referral being declined).

Hyperactivity

Do you experience hyperactivity? If so, what does this look like for you? **What do other people in your life notice?**	

What impact does hyperactivity have on your life at present?	
Were these difficulties evident in childhood?	**Yes** ☐ **No** ☐

Difficulties with Attention, Focus and Concentration

Do you experience any difficulties with sustaining attention, focus and concentration? **If so, what does this look like for you?** **What do other people notice?**	
What impact do your difficulties with attention, focus and concentration have on your life at present?	
Were these difficulties evident in childhood?	**Yes** ☐ **No** ☐

Impulsivity

Do you experience any difficulties with impulsivity? **If so, what does this look like for you?** **What do other people in your life notice?**	
What impact does impulsivity have on your life at present?	
Were these difficulties evident in childhood?	**Yes** ☐ **No** ☐

Have you had a diagnostic assessment for ADHD in the past?	**Yes** ☐ **No** ☐ If yes, please give more information
Are you currently on a waiting list for an ADHD diagnostic assessment with another service?	**Yes** ☐ **No** ☐

Section C - Please fill in all the questions below for both new diagnostic & medication treatment referrals

Mental Health

Are you experiencing any current mental health difficulties?	**Yes** ☐ **No** ☐ If yes, please share more information about these difficulties and/or diagnosis:
Are you currently accessing any other services in relation to your mental health at present?	**Yes** ☐ **No** ☐ Please give details.
Are you currently experiencing a mental health crisis including any plans/thoughts to end your life?	**Yes** ☐ **No** ☐ If you are experiencing a mental health crisis, feeling suicidal or in need of urgent support to keep you safe, then please phone crisis support for free on the numbers below: • Crisis line: 0800 804 8999 • Phone: 111 and select the mental health option Please note we cannot offer any crisis or mental health support whilst patients are waiting or receiving care from our service.
Please tick to say that you have read this section	**Yes** ☐

Additional Information:

Please indicate if this referral is to help with:	☐ Current difficulties with employment ☐ Current difficulties in an education setting ☐ Current difficulties with your day-to-day functioning. ☐ Understanding your mental health ☐ Other (Please specify)

Is there anything else you would like us to know?	

Disclaimer Statement

By submitting this referral form, you are consenting for the ADHD team to access your NHS electronic summary health care record as part of the information gathering process. A copy of this referral form will be uploaded on to your NHS electronic health care record.

Thank you for completing this referral form, once we have reviewed your form, we will get back to you to let you know whether your referral has been accepted or not.

Please sent to:

Email: rdash.adhdandautismreferrals@nhs.net

Central Address: RDASH Adult Neurodiversity Service, The Neurodiversity Centre, Askern Road, Doncaster, DN5 0JR