IVEL MEDICAL CENTRE

Adult ADHD Referral Request Form & Supporting Information

Please provide examples from childhood and adulthood where possible.

1. Patient Details

Full name: _____

Date of birth: _____

Contact number: _____

Parent/carer name (if applicable): _____

Relationship to patient: _____

2. Referral Required

Please tick the relevant option:

☐ ADHD assessment

☐ ADHD transfer of care

3. Referral Pathway

☐ Local NHS service (adult assessment)

☐ NHS Right to Choose

If requesting Right to Choose, please provide the full name of your chosen provider:

4. Symptoms and Difficulties

Please describe the difficulties you experience and why you are seeking an ADHD assessment.

5. Childhood Symptoms

At approximately what age did your difficulties begin?

Please describe any difficulties you experienced during childhood.

6. Education

Please describe how your difficulties have affected your education, including academic achievement, behaviour, concentration and any additional support required.

7. Employment

Please describe how your difficulties have affected your employment, including organising and completing tasks, managing responsibilities, workplace relationships and reasons for leaving previous jobs, where relevant.

8. Social Relationships

Please describe how your difficulties have affected your friendships, family relationships and social interactions, both during childhood and currently.

9. Daily Living

Please describe how your difficulties affect your everyday life, including organisation, household tasks, self-care, managing appointments and finances.

10. Patient Declaration

I confirm that I have read, or had explained to me, the ADHD and Autism Assessments information on the practice website.

I understand that:

- My referral request is subject to clinical review and provider eligibility criteria.
- An ADHD diagnosis does not automatically mean that the practice will take over prescribing or monitoring my medication.
- The practice routinely considers ADHD shared care agreements from the local NHS commissioned ADHD service and Psychiatry-UK under NHS Right to Choose.
- Shared care agreements from other providers are not routinely accepted.
- All shared care requests are subject to individual clinical review and acceptance is not guaranteed.
- I should check my chosen provider's arrangements for ongoing prescribing, monitoring and specialist follow-up.

Signature: _____

Print name: _____

Date: _____

Returning Your Form

Please return this completed form to the practice.

Your request will be reviewed and if further information or an appointment is required, we will contact you.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an **X** in the box that best describes how you have felt and conducted yourself over the past **6** months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never (0)	Rarely (1)	Sometimes (2)	Often (3)	Very Often (4)
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
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 were 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 turn taking is required?					
18. How often do you interrupt others when they are busy?					