**The Plymouth Adult Attention Deficit Hyperactivity Disorder (ADHD) Assessment Service Referral Form**

The Plymouth Adult ADHD Assessment Service offers ADHD assessment to individuals living in the Plymouth area aged 18 years and above.

**This referral form is for the Adult ADHD Assessment Team who conduct diagnostic assessments.**

**Please note that** **we are unable to manage any mental health needs the client may have whilst they are waiting for an ADHD assessment.** If you think that your client needs support regarding their mental health, please ensure they access the appropriate services whilst waiting for an assessment.

Please note we ONLY accept referrals from clinicians (GP or other professionals) for ADHD assessments and do not accept self-referrals.

**GP’s and Primary Care Professionals** please send your completed referral form via the Devon Referral Support Service (DRSS)

**Secondary Care Professionals** please send your completed referral form to livewell.AdultADHDassessment@nhs.net

If you have any queries regarding completing this referral form, please email livewell.AdultADHDassessment@nhs.net or phone on 01752 435452

**We can only accept referrals for clients who:**

* **Are aged 18 or over**
* **Are registered with a Plymouth GP**
* **Do not already have a diagnosis of ADHD**
* **Do not have a diagnosis of Learning Disability**
* **Where there is evidence of difference that may relate to ADHD**

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| --- | --- | --- | --- |
| **Client details:** | | | |
| Name: | <Patient Name> | Date of Birth: | <Date of Birth> |
| Gender: | <Gender> | NHS Number: | <NHS number> |
| Address: | <Patient Address> | Telephone number: | <Patient Contact Details> |
| **Our first preference is to correspond with our clients via email.** | Email Address: | **<Patient Contact Details>** | |
| **Referrer details:** | | | |
| Name: | <Your Name> | Telephone number: | <Organisation Details> |
| Role: |  | Email address: | <Organisation Details> |
| Service / organisation: | <Organisation Address> | Relationship to client: |  |
| **GP details (if different to above):** | | | |
| GP Name: |  | Telephone number: |  |
| Surgery |  | Email address: |  |
| Address: |  |  | |

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| --- | --- |
| **Reasonable Adjustments:** | |
| Please detail any reasonable adjustments that the individual may need to help them access our service (this could include interpreters, easy-read information, shortened appointments, contact through a carer or supporter etc.). | |
|  | I am not aware of any need for reasonable adjustments |
|  | I am aware of the following reasonable adjustments: |
|  | |

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| --- | --- | --- | --- | --- |
| **Has your patient/client consented to a referral for an ADHD Assessment?** | | | | |
| **Patient consent is required for referral.** | | | | |
|  | | I have checked and my patient has consented to this referral | | |
|  | | I do not know if my patient has consented to the referral – see reasons below | | |
| **Reason for Referral:** | | | | |
| Including past diagnosis of ADHD or any other neurodevelopmental disorder (attach reports if available) | | | | |
|  | | | | |
| **Physical health checklist for ADHD referral:**  **Referrer to Complete:** | | | | |
| Blood pressure <Latest BP>  Pulse rate  Weight <Latest Weight>  Height <Latest Height> | | | | |
| **History of Physical health for Individual and Family members.**  **Referrer to Complete:** | | | | |
| History of cardiovascular disease  History of tics or epilepsy  Family history of cardiovascular disease before age 55  History of liver disease | | | | |
| **Current Medication:** | | | | |
| <Medication(table)> | | | | |
| **History of mental health diagnosis and treatment:** | | | | |
|  | I am not aware of any mental health difficulties and treatment. | | | |
|  | I am aware of the following mental health difficulties and treatment: | | | |
|  | | | | |
| **Safeguarding Information:** Please provide any safeguarding information: | | | |  |
|  | I am not aware of any safeguarding alerts: | | | |
|  | I am aware of the following safeguarding alerts: | | | |
|  | | | | |
| **Risk:** We are not able to manage risk while an individual is on our waiting list. If you have concerns, these should be managed by other services/professionals involved in the client’s care. Please include Risk of harm to self, Risk of harm to others, Forensic history: | | | | |
|  | | | I am not aware of any risk to the person, others, or professionals. | |
|  | | | I am aware of the following risks: | |