Child/Young Person ADHD Referral form

Date:	**Referred by:**			
	Referral form completed by:			
Child/Young Person Details: (Please include any previous name/otherwise known as)				
Surname:	**Forenames:**	**D.O.B:**		
Gender:	**Sexual Orientation:** (LGBTQIA-specify)	**Ethnicity:**	**Nationality:**	**Religion:**
NHS number:		**URN** (ADHD Foundation Staff use only)		
Current Address: Postcode: Telephone: Mobile: Email: **Name of Parent/Carer at above address:** **Parental Responsibility:** Yes ☐ No ☐ **Any shared PR:**		**Alternative Address:** Postcode: Telephone: Mobile: Email: **Name of Parent/Carer at above address:** **Parental Responsibility:** Yes ☐ No ☐ **Any shared PR:**		
Emergency contact name/Number:				
Community Paediatrician:		**GP Name/Surgery:**		
Has the child/Young person been <u>diagnosed</u> with <u>any</u> conditions? Please ensure to include ALL disabilities, ill health, or medical conditions, including if they need to wear glasses when using a laptop. Please also disclose if <u>you</u> or the child/young personhave contracted Covid-19 or have been in contact with someone who has and when this was.		**What conditions are currently being explored?**		

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Current Medication:	**History of Brain injury or brain illness (severe enough to cause concussion and/or medical treatment). If yes please state when and the severity:**	
Does the child/young person have a history of heart disease?	**Do they have a history of fainting?**	**History of suicidal ideation or self harm?**
Do they have a history of high blood pressure?	**Is there a history of epilepsy in the family?**	
Are you aware of any genetic conditions? Such as Raynaud's syndrome	**Has the child/young person been assessed for DCD? (Developmental coordination disorder). If so what was the outcome**	
Has the child/Young person experienced any traumatic experiences which may have resulted in post traumatic stress disorder?	**Has the child/young person been assessed for dyslexia, dyscalculia, dysgraphia or dyspraxia? If they have what was the outcome?**	
Has the child/young person being screened for sensory processing disorder? If so what was the outcome?	**Is there a history of ADHD in the family? If so who?**	
Is there a history of Autism in the family? If so who?	**Is there a history of Tourette's/tics in the family? If so who?**	
Is there a history of Sensory processing disorder? If so who?	**Has the child/young person been assessed for any language disorders e.g. receptive language disorder?**	

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Any other agencies involved: e.g. CAMHS, Alder Hey e.t.c.	
Education Status: (e.g. Main Stream/Home Taught)	
School Address:	**Has the child/YP ever been excluded?** Yes ☐ No ☐ (If yes please give brief details/action)
Does the child/young person have an Education, Health and Care Plan (EHCP) in place? Yes ☐ No ☐	
Class Teacher: **Tel no:**	**SENCO:** **Tel no:**
Year Group:	**Home Language:**
Attendance (circle): **over 96% / 90-96% / under 90%**	**EYFS (developmental stage)** **Communication & Language:** **Physical:** **Personal, Social & Emotional:**
Does the child/young person take part in any activities in or outside school?	
Why do you think the child/young person has ADHD?	

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What are the barriers to learning for this child as you see them?
Do you have any concerns about alcohol or substance misuse?
Any Police Involvement/Risk? (Brief details)
Any Significant/Relevant Information which you feel may be beneficial to the appointment? (e.g. Child Protection/Looked after)

Does the child/parent/carer have any accessibility requirements (including hearing, large print documents)	Yes ☐ No☐ Don't Know ☐	If yes, please provide details:

Interpreter required? Yes ☐ No ☐

Please confirm that you have read, understood, and agree to the policies detailed in the information guide, and that you consent to the ADHD Foundation Neurodiversity Charity recording, processing and sharing your information.
(This is not related to marketing, it enables us to process and accept the referral e.g. adding you to our waiting list. If you do not tick this box we will not be able to accept the referral form and proceed with the booking).
☐

Please tick which service you are referring to:

Child/Young person FULL assessment ☐

Child/Young person QbTest Only ☐

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