**Adult ADHD Assessment Referral Form**

**Please send completed form plus supporting documents to the Xyla clinical team at** **xyla.rtc@nhs.net**

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| **IMPORTANT – Choice of Provider:****Which is the chosen provider to refer to?**[x]  **Xyla**  |

* Please ensure that all clinical information required in Section 8 is submitted together with the Referral form, together with any relevant reports. Failure to do so will result in delays for your patient.
* **Please note that the patient will be discharged back to the GP once stabilised on medication as annual reviews will be undertaken in primary care**

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| 1. **PATIENT DETAILS**
 | 1. **REFERRER DETAILS**
 |
| Name |  | Date of Referral |  |
| DOB |  | Name of Referrer |  |
| NHS No. |  | Role of Referrer (if not GP) |  |
| Address |  | Name of GP (if not referrer) |  |
| Mobile  |  | GP Surgery |  |
| Home phone  |  | Address  |  |
| Email |  |  |  |
| Gender |  | GP Telephone |  |
| Ethnicity |  | GP Practice Email (NHSmail) |  |
| Disabilities/Reasonable Adjustments required |  | Bypass number for queries | Use [NHS Service Finder](https://servicefinder.nhs.uk/login)to access Bypass number.  |
| Interpreter needed? | [ ]  Yes [ ]  No |
| Main Language spoken |  |

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| 1. **REASONS FOR REFERRAL**
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| *Please summarise: symptoms the patient is experiencing suggestive of ADHD / other; how day to day living is affected, and any co-morbid mental health or neurodevelopmental conditions or substance misuse:* |
| ADHD Diagnosis previously made?  | [ ]  Yes - Details: [ ]  No  |
| Patient currently on ADHD medication?  ADHD medication? | [ ]  Yes - Details: [ ]  No  |
| Patient open to a mental health service? | [ ]  Yes - Which service?      [ ] No:       |
| Does patient have history of contact with CAMHS? | [ ]  Yes- Details:       [ ]  No  |
| Has the patient consented to this referral?  | [ ]  Yes [ ]  No - Details why not:       |
| 1. **GOAL(S) OF REFERRAL – please consider both assessment and potential ongoing treatment.**
 |
| *Please include patient opinion and expectation:*        |
| 1. **SUMMARY OF RISK – please include suicide, self-harm and harm towards others.**
 |
| [ ]  Suicide | [ ]  Safeguarding |
| [ ]  Self harm/ Risk taking behaviours | [ ]  Risk to others/ violent behaviour/ forensic history? |
| [ ]  Self neglect | [ ]  Alcohol/Substance misuse (with primary MH need): |
| Details/ other:       |
| Current/previous history of domestic abuse/violence?  | [ ]  Yes [ ]  No |
| Any children (living with patient) aged under 18 years? | [ ]  Yes [ ]  No |
| Currently pregnant or up to 2 years post-partum?  | [ ]  Yes [ ]  No |
| Subject to Leaving Care provisions?  | [ ]  Yes [ ]  No |
| 1. **RELEVANT MEDICAL, PSYCHIATRIC OR FORENSIC HISTORY**
 |
| **Please confirm you will share patient records data with the** **provider** (subject to data sharing agreement) [ ]  Yes [ ]  No |

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| 1. **MEDICATIONS & ALLERGIES**
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| **Past Mental Health Medication** - Please provide details of any past medication which might not have been effective or tolerated: |

**Acute Medication in the last 1 month**

| **Start date** | **Drug name** | **Dose** |
| --- | --- | --- |
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**Repeat Medication**

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| **Drug name** | **Dose** | **Last issued** |
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**Repeat Medication**

No current repeat medication

**Allergies & Sensitivities**

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| **Start date** | **Allergy (no Read Code) or Sensitivity** | **Details** |
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| 1. **REQUIRED CLINICAL INFORMATION**
 |
| **Test** | **Result** | **Date** |
| BP |  |  |
| Pulse |  |  |
| BMI |  |  |
| Blood results: FBC, U&E, blood sugar, serum creatine, LFTs, TFTs | Please attach if not merged below |
| ECG | Please attach |

**Blood Results – not mandatory for initial referral**

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| **TEST** | **RESULT** | **DATE** |
| **Full Blood Count** |
| Haemoglobin concentration |  |  |
| Total White Blood Count |  |  |
| Mean Cell Volume |  |  |
| Platelet Count |  |  |
| Reactive Protein |  |  |
| **U&E** |
| GFR Calculated |  |  |
| Serum Creatinine Level |  |  |
| Serum Sodium Level |  |  |
| Serum Potassium Level |  |  |

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| **Liver Function Tests** |
| Serum alanine aminotransferase level (ALT) |  |  |
| Serum alkaline phosphatase level (ALP) |  |  |
| Serum Bilirubin level  |  |  |
| Gamma-glutamyl transferase level (GGT) |  |  |
| Aspartate transaminase (AST) |  |  |
| Serum Albumin level: |  |  |

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| **Thyroid Function Tests** |
| Serum TSH level (depending on symptoms) |  |  |
| Serum T4 level (depending on symptoms) |  |  |

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| **ECG** |
| Electrocardiogram |  |  |