A close up of a logo

Description automatically generated

**Referral to the ADHD Service**

Part 2 – to be completed by the patient and/or family. Please complete all sections as fully as you can.  
Once completed please return to your GP who will complete their part of the referral before sending on to the ADHD service (SAAS@SOMERSETFT.NHS.UK).

|  |  |  |
| --- | --- | --- |
| Name |  | DOB |
| Current Address |  | |

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| --- | --- | --- |
| **Main Problems** | | |
| What are your main problems? *i.e. inattention, hyper-activity, impulsivity* |  | |
| What is the impact of the problems on these areas of your life? | Education/Employment |  |
| Personal/Social relationships |  |
| Self-concept/  view of self |  |
| Other |  |
| Childhood Symptoms of ADHD (before the age of 12) | Impact on school /learning problems |  |
| Impact on Family/ Parental/ Friendships |  |
| Risk taking/ Accidents |  |
| General Behaviour |  |

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| **Developmental History – did you have any of the following?** | | | | | | |
| Pregnancy Complications |  | Delay / Accelerated Developmental Milestones |  | Behavioural Issues | |  |
| Birth Complications |  | Settling/Sleep Problems |  | Sensory Processing Difficulties  (i.e. problems such as high or low sensitivities to light, sounds, pain, heat and taste) | |  |
|  |  | Feeding/Eating Problems |  | Social interaction Issues | |  |
| If Yes to any, please describe problem and any investigations and treatment. | |  | | | | |
| Any Developmental Diagnoses?  *i.e. autism, specific learning difficulty, learning disability etc.* | |  | | | | |
| Any Childhood adverse events?  *i.e. trauma, abuse, parental mental health problems, parental substance abuse etc.* | |  | | | | |
| **Family History** | | | | | | |
| Any known family history of ADHD?  *Please give details of familial relationship and diagnosis* | |  | | | | |
| Any known family history of the following?  *i.e. autism, specific learning difficulty, learning disability, dyslexia, dyspraxia, dyscalculia,*  *anxiety, depression, OCD, Tourette, psychosis, alcohol or substance use problem, genetic disorder, cardiovascular problems* | |  | | | | |
| **Educational/Work History** | | | | | | |
| Currently in Education? | | School / College | Higher  Education | | No | |
| Please give details of the schools attended and any problems in school /education  School reports available  Yes  No | |  | | | | |
| Currently working? | | Employed | Self-employed | | Not in work | |
| Please give details of any problems in work/employment? | | Peers / Colleagues:  Managers:  Time Management: | | | | |
| Preferred type of work | |  | | | | |
| **Sleep, Drug and Alcohol History** | | | | | | |
| Any sleep issues?  *In the past 4 weeks, on average, how many hours of sleep do you get per night?*  *How often daytime nap in a week?*  *Bedtime?*  *How long does it take to fall asleep?*  *Sleep more often broken or solid?*  *Waking up time?*  *Morning or evening type?* | |  | | | | |
| Current weekly alcohol intake (units per week, on average) | |  | | | | |
| Current cannabis use (on average per week) | |  | | | | |
| Use of other recreational substances, in particular stimulant drugs e.g. Cocaine, Amphetamines, MDMA etc | | Effect:  Current usage:  Past usage: | | | | |
| Current caffeine intake (coffee, energy drinks etc) | |  | | | | |
| Current Nicotine intake (cigarettes and vaping)? | |  | | | | |

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| **Adult ADHD Self-Report Screening Scale for DSM-5 (ASRS-5)**  Check the box that best describes how you have felt and conducted yourself over the past 6 months. Please give the completed questionnaire to your healthcare professional during your next appointment to discuss the results. | | | | | |
|  | Never | Rarely | Sometimes | Often | Very Often |
| 1. How often do you have difficulty concentrating on what people are   saying to you even when they are speaking to you directly? |  |  |  |  |  |
| 1. How often do you leave your seat in meetings or other situations in   which you are expected to remain seated? |  |  |  |  |  |
| 1. How often do you have difficulty unwinding and relaxing when you have   time to yourself? |  |  |  |  |  |
| 1. 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? |  |  |  |  |  |
| 1. How often do you put things off until the last minute? |  |  |  |  |  |
| 1. How often do you depend on others to keep your life in order and attend   to details |  |  |  |  |  |