**Referral form**

**Adult ADHD Service**

Please complete all sections, this information will ensure referrals are managed in an efficient manner and reduce unavoidable delays caused by requests for further information. If you need advice about the referral process or suitability of your referral you are welcome to contact us by telephone to discuss the referral. We would encourage anyone in doubt about whether referral is appropriate to contact the service and speak to a member of the clinical team who will be happy to provide advice.

We accept referrals from health care professionals but need the agreement of the GP to undertake shared care. **Once the form has been completed please return to:**

Adult ADHD Service

Adult Neurodevelopmental Service Specialist Services

Keegan Court

Grassbanks

Gateshead

NE10 8DX

0191 287 6250

ADHD@cntw.nhs.uk

**Referral Exclusions**

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| **No evidence of ADHD symptoms prior to the age of 12.**Guidelines for diagnosing ADHD in adult’s state symptoms need to be present prior to the age of 12 as it is a neurodevelopmental disorder. A referral for assessment by local Community Health Services may be more appropriate in this case. |
| **Possibility of an untreated mood disorder or other mental health diagnosis.**If the symptoms described by the patient could indicate another mental health disorder which they have not been assessed or treated for, the NICE Guidelines recommend this is investigated prior to assessing for ADHD. A referral to local mental health services would be recommended in these cases.  |

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| **Referrer** |  | **Telephone Number** |
| **Address** |  | **When did you last see the service****user?** |

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| **GP****(If not the referrer)** |  | **Telephone Number** |
| **Address** |  | **E-Mail Address** |
| **Name of Service****User** |  | **Date of Birth****Ethnicity (Please tick appropriate)**Asian or Asian British – BangladeshiAsian or Asian British – Indian Asian or Asian British – Pakistani Asian/Asian British/Other Asian BackgroundBlack or British – AfricanBlack or British – CaribbeanBlack/Black British/Other Black Background Mixed – Any other mixed backgroundMixed – White and Asian Mixed – White and Black AfricanMixed – White and Black CaribbeanOther Ethnic Groups – ChineseOther Ethnic Groups - Other Ethnic GroupWhite – British White – Irish White – Other |
| **Address** |  | **NHS Number** |
| **Telephone Number****E-Mail address**  |
|  |  | **Patient has given consent to the referral Y/N?****Patient has given consent to onwards referrals Y/N?** |
| **Will the person consider online consultation?** | **Yes**  | **No**  | **Don’t know** | **You will need access to a computer/tablet/smartphone, with microphone, camera & Wi-Fi.** **You will need to provide email address as above.**  |

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| **What is the reason for referral?****In the box below, please describe any possible symptoms of ADHD the patient is presenting with – this can include problems with attention, concentration, hyperactivity and impulsivity.** **Please comment on the impact this is having on relationships, employment/education and daily life.** |
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| **Please provide information regarding any historic or current self-harm, suicidal thoughts, or harm to others including any child or adult safeguarding issues.**  |
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**Signed: Date:**

**Print:**

**Updated 15.4.24**

**Review 15.4.25**