

North Cumbria Childrens ADHD Service

**Parent/Carer Information Request Pack**

**Referrals will only be accepted using the referral packs.**

It is expected that the referring practitioner will coordinate the completion of the pack, which includes various questionnaires for the school/education setting, parents/carers and in some instances, the young person to complete. If this is not received with the referral form, we will send a request for this information to be completed.

The completed referral pack will then need to be emailed to CMB-ADHDNCumbria@cntw.nhs.uk

**Please be aware we only accept electronic referrals.**

On receipt of the fully completed referral pack, the multidisciplinary panel will screen these to assess whether further ADHD assessment is appropriate. If this is agreed, **this will be added to the waiting list for ADHD assessment.**

If we review all the information and decide that the evidence suggests that the young person does not need further ADHD assessment, then they **will not be added to the waiting list for this and their referral to the ADHD assessment service will be closed**. However, we will make recommendations of further support or assessment that may be helpful.

If you need any support completing this pack, please speak to the referrer.

Please make sure you have

* Given as many examples as possible
* Have provided any additional information you want us to know about



**PARENT/CARER INFORMATION REQUEST PACK**

**PLEASE COMPLETE THIS FORM IN FULL AND RETURN TO**  CMB-ADHDNCumbria@cntw.nhs.uk

**PLEASE NOTE: WE WILL CONTACT SCHOOL/COLLEGE FOR INFORMATION SEPARATELY**

|  |  |  |  |
| --- | --- | --- | --- |
| Young Persons DetailsSurname:  |  | Forename: |  |
| Date of Birth |  | Is your child | Looked after child **☐**Adopted **☐**Fostered **☐**special guardianship ☐ |
| Religion |  | Ethnicity  |  |
| Name of person completing this form |  |
| Relationship to child |  |
| Contact number |  |
| Email address |  |
| Language spoken at home |  |

**Has your child previously been assessed in relation to ADHD?**

**Yes ☐ No ☐**

**If yes, please specify when, where and who by:**

**Sharing and gathering information about you**

As part of your assessment and treatment we gather information from other services, agencies and in combination with what you tell us about yourself, as this helps us to get a clear picture of your history and current needs, as well as any risk of harm to yourself or others.

The information gathering process will only relate to records that are relevant to your assessment and with the information you give us will be kept in your Health Record (written and computerised) to help us to provide you with the most appropriate care.

We have a duty to keep information about you private and confidential. However, in certain circumstances, there may be occasions where it is necessary to share information without your consent to protect you, or someone else, from harm. In these circumstances we will tell you that we are going to share information, what that information is and who we will share it with.

|  |
| --- |
| **Do you consent to us seeking and sharing information as part of your assessment and treatment?**  |
| **Yes** | **No** |
| **Are there any people you do not want us to contact?** |
| **Yes** | **No** |
| **Name(s)** | **Address** | **Relationship** |
|  |  |  |
|  |  |
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|  |
| --- |
| **Statement of patient/parent/carer (only to be completed by parent/carer where the decision falls within the scope of parental responsibility or with the consent of a competent child/young person)** |
| I give consent for ADHD services to access my/ my child’s/ young person’s records  |
| **Print Name** |  | **Signature** |  | **Date** |  |
| **Relationship to young person** |  |

**To help us understand your child/ young person’s needs, we need some additional information about family circumstances, developmental history, and the young persons difficulties. This information is personal and sensitive and will help us to process the referral and support the assessment process.**

Reason for Referral (what are you asking the ADHD team to do?)

Tell us about your child/young person’s strengths

What are the biggest challenges for your child/young person right now?

When did you first have concerns and what was this about?

Tell us about any actions or approaches you use at home to support your child/young person

Adults living at home

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Date of Birth** | **Relationship to the child** | **Contact Details** | **Parental responsibility**  |
|  |  |  |  | **Yes ☐****No ☐** |
|  |  |  |  | **Yes ☐****No ☐** |
|  |  |  |  | **Yes ☐****No ☐** |
|  |  |  |  | **Yes ☐****No ☐** |
|  |  |  |  | **Yes ☐****No ☐** |

**Where parents are separated, what are contact arrangements:**

Siblings

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Date of Birth** | **School** | **Any health/ learning needs** | **Living at home** |
|  |  |  |  | **Yes ☐****No ☐** |
|  |  |  |  | **Yes ☐****No ☐** |
|  |  |  |  | **Yes ☐****No ☐** |
|  |  |  |  | **Yes ☐****No ☐** |
|  |  |  |  | **Yes ☐****No ☐** |

**Medical History**

**Pregnancy details**

|  |  |  |
| --- | --- | --- |
| **Pregnancy details** | **Yes/No**  | **Please explain further**  |
| Any previous miscarriages or stillbirths? | **Yes ☐****No ☐** |  |
| Did biological mother have any fever or infection during pregnancy  | **Yes ☐****No ☐**  |  |
| Did biological mother have medical or mental health difficulties during the pregnancy? | **Yes ☐****No ☐** |  |
| Did biological mother require medication during the pregnancy e.g sodium valproate, gentamicin)  | **Yes ☐****No ☐** |  |
| Did biological mother smoke or drink alcohol during the pregnancy? | **Yes ☐****No ☐** |  |
| Did biological mother use street drugs during the pregnancy? | **Yes ☐****No ☐** |  |
| Were there any concerns about the baby’s growth or health from antenatal scans? | **Yes ☐****No ☐** |  |
| Did biological mother experience any traumatic events during the pregnancy? | **Yes ☐****No ☐** |  |

**Birth Details**

|  |  |
| --- | --- |
| **Birth details** | **Please explain further**  |
| Were there any complications during pregnancy? |  |
| Was baby born at full term of pregnancy? | **Yes ☐****No ☐** |
| If not, how early or late were they? |  |
| Was the delivery:  | **Normal ☐****Forceps ☐****Vacuum ☐****C-Section ☐** |
| Were there any complications during birth? |  |
| Did the mother have a difficult labour? |  |
| How long was labour? |  |
| Birth weight: |  |
| Please give details of any difficulties after birth: |  |
| Did the baby require special neonatal care / support? | If yes, for how long: |
| Did mother have any postnatal depression? |  |

**Child Development**

|  |  |  |
| --- | --- | --- |
| **Please state at what approximate age your child did the following:** | **Age**  | **Comments**  |
| Crawling: |  |  |
| Walking alone without support: |  |  |
| Speaking: |  |  |
| Smiling freely and appropriately towards you and others: |  |  |
| Showing you things by pointing at them and looking back at you: |  |  |
| Playing games like peek-a-boo:  |  |  |
| Playing with objects by pretending to talk/imaginative play: (e.g., talking on the phone/feeding a doll/flying a toy aeroplane etc.) |  |  |
| Staying dry during the day: |  |  |
| Staying dry during the night: |  |  |
| Did the health visitor have any concerns about your child’s development in early years? |  |  |
| Did your child have speech and language assessments or therapy? |  |  |

**Childs Health**

|  |  |  |
| --- | --- | --- |
| **Has your child** | **Yes/No**  | **Please explain further**  |
| Ever been admitted to hospital? | **Yes ☐****No ☐** |  |
| Ever had any seizures, fits, faints, or other loss of consciousness? | **Yes ☐****No ☐**  |  |
| Any other medical conditions or problems? | **Yes ☐****No ☐** |  |
| Ever had a head injury? | **Yes ☐****No ☐** |  |
| Had a hearing test? | **Yes ☐****No ☐** |  |
| Had a vision test? | **Yes ☐****No ☐** |  |
| Any medication/food allergies? | **Yes ☐****No ☐** |  |
| Are immunisations/ vaccinations all up to date? | **Yes ☐****No ☐** |  |
| Are any prescribed or over-the-counter medications taken regularly? |  |  |

**Concerns**

|  |  |
| --- | --- |
| **Concern** | **Please explain further**  |
| **Appetite and/or diet?**e.g., limited diet, love of particular foods, eating habits |  |
| **Sleep?**e.g., short periods of sleep, difficulties with napping/settling, difficulty going to bed, waking up during the night |  |
| **Coordination and balance?**e.g., appear clumsy, bumps into things, struggles with hand-eye co-ordination, difficulty riding a bike |  |
| **Use of self-care skills?** (e.g., eating / feeding / dressing / using cutlery / toileting) |  |
| **Unusual sensitivity to noise / taste / texture / pain?** |  |
| **Tics**e.g., involuntary body movements, noises |  |
| **Obsessions / compulsions?**e.g., something that the individual needs to do (e.g., a routine they must follow) |  |
| **Repetitive or unusual behaviours?**e.g., rocking, pencil tapping, fidgeting, leg shaking |  |
| **Problems with mood and/or self – esteem?**e.g., difficulty understating their own mood and that of others, low opinion of themselves, worry about things wrong |  |
| **Specific fears/phobias?** |  |
| **Has your child had any extra help at previous school or nursery with their learning, behaviour, or other issues?**  |  |

**SNAP-IV**

In answering the following questions, please consider whether the behaviour has persisted **for at least 6 months**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **For each item, select the box that best describes this child. Put only one check per item.** | Not at all0 | Just a Little1 | Quite a Bit2 | Very Much3 |
|  |  |  |  |  |
| 1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
 |  |  |  |  |
| 1. Often has difficulty sustaining attention in tasks or play activities
 |  |  |  |  |
| 1. Often does not seem to listen when spoken to directly
 |  |  |  |  |
| 1. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties
 |  |  |  |  |
| 1. Often has difficulty organising tasks and activities
 |  |  |  |  |
| 1. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework)
 |  |  |  |  |
| 1. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
 |  |  |  |  |
| 1. Often is distracted by extraneous stimuli
 |  |  |  |  |
| 1. Often is forgetful in daily activities
 |  |  |  |  |
|  |  |  |  |  |
| 1. Often fidgets with hands or feet or squirms in seat
 |  |  |  |  |
| 1. Often leaves seat in classroom or in other situations in which remaining seated
 |  |  |  |  |
| 1. Often runs about or climbs excessively in situations in which it is inappropriate
 |  |  |  |  |
| 1. Often has difficulty playing or engaging in leisure activities quietly
 |  |  |  |  |
| 1. Often is “on the go” or often acts if “driven by a motor”
 |  |  |  |  |
| 1. Often talks excessively
 |  |  |  |  |
| 1. Often blurts out answers before questions have been completed
 |  |  |  |  |
| 1. Often has difficulty awaiting turn
 |  |  |  |  |
| 1. Often interrupts or intrudes on others (e.g., butts into conversations/games)
 |  |  |  |  |

### What is the young person’s behaviour like at home?

Please give specific examples:

Does the young person often find it difficult to give close attention to details; or makes careless mistakes with his/her homework, or struggles to understand tasks and instructions?

Please give specific examples:

Does the young person often have difficulties sustaining attention with tasks and play activities?

Please give specific examples:

Does the young person often not seem to listen when spoken to directly, for example their mind seems elsewhere?

Please give specific examples:

Does the young person follow through with instructions?

Please give specific examples:

Does the young person have difficulties organising tasks and activities?

Please give specific examples:

Does the young person get distracted easily and can they get organised for a task?

If yes give examples:

**Communication**

|  |  |
| --- | --- |
| **Communication**  | **Please explain further**  |
| Do they understand and use non-verbal ways of communicating (e.g., pointing, gestures, facial expressions, body language)? |  |
| Can they take turns and listen in conversations? |  |
| Do they initiate conversations with others? |  |
| Do they understand when you ask them to do something? |  |
| Do they understand idioms (e.g., Better Late Than Never) metaphors (e.g., Has a Heart of Gold), sarcasm etc? |  |

**Relationships with peers**

|  |  |
| --- | --- |
| **Relationships with peers**  | **Please explain further**  |
| Friendships (can they approach others, join in, respond appropriately, allow others to take the lead in a game etc)? |  |
| How do they manage fall outs with friends? |  |
| Can they work with others? (e.g., co-operate, understand others perspectives, listen to different viewpoints, take turns)? |  |
| Can they understand other’s thoughts and feelings and respond appropriately/ (Empathy)? |  |

**Routines**

|  |  |
| --- | --- |
| **Routines** | **Please explain further**  |
| Do they like to have routines? How do they respond if this change?  |  |
| How do they respond to rules? How do they respond to other people not following rules? |  |
| What are their interests?  |  |
| How do they manage with unstructured times (such as break times in school or times at home if there is not a plan/routine set up)? |  |
| What are there play skills like? Do they/did they play imaginatively? Are they creative? Do they let others join their games?  |  |

**Sensory Needs**

Are you aware of any sensory needs? Our senses include:

* Vision
* Hearing
* Taste
* Smell
* Touch
* Balance (vestibular)
* Body awareness (Proprioception – where our body is in space)
* Internal sense (Interoception – do we feel hungry, hot, cold, poorly etc)

|  |  |
| --- | --- |
| **Sensory needs**  | **Please explain further**  |
| Are they over or under sensitive?  |  |
| Do they lack sensitivity to pain?  |  |
| Do they know how much pressure they are using when playing physical games? |  |
| Do they know if they are hot/cold/hungry etc.? |  |
| Do they show interest in features of their environments such as the lights, the smells etc? |  |

If you have any other information that may be helpful, please provide details:

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**SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**JOB ROLE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THANK YOU FOR COMPLETING THIS FORM. PLEASE RETURN TO** CMB-ADHDNCumbria@cntw.nhs.uk