NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Referral form

Service for adults with ADHD

Date of referral

Referrer details

Name

Address

Telephone number

Designation

Details of person referred

Name

NHS number

RiO number

Gender Male ☐ Female ☐

Date of birth

Current address

Telephone numbers Home Mobile

Has the person consented to this referral? YES ☐ NO ☐

Does the person have any communication needs and/or require information in a format other than standard print? YES ☐ NO ☐

If YES, what are the person's needs?

Does the person want someone to contact us on their behalf (e.g. partner, parent) when arranging an initial appointment? YES ☐ NO ☐

If YES, name and contact details

Does the person have a diagnosed global learning disability? YES ☐ NO ☐

If YES, we will be unable to accept your referral.
Please contact your local Learning Disability Services.

GP details

Name

Surgery address

Telephone number

Reason for referral

☐ Diagnostic assessment of ADHD

☐ Medication review for someone already diagnosed with adult ADHD

☐ Non-medication based interventions

Please note: Referrals for intervention can only be accepted if the diagnosis has already been confirmed. If this is the case please attach a copy of the diagnostic report.

ADHD: key features

Please answer the questions below, rating yourself on each of the criteria shown using the scale below. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during the appointment.

	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?					
2. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
3. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
4. 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?					
5. How often do you put things off until the last minute?					
6. How often do you depend on others to keep your life in order and attend to details?					

Please provide examples of any current difficulties the person has in the following areas:

Inattention	Details

Hyperactivity	Details

Impulsivity	Details

Has the person had any of the following:

Problems in obtaining or sustaining education or employment	Details

Difficulties in initiating or sustaining social relationships	Details

Previous or current contact with mental health	Details

A previous diagnosis of a mental health or neurodevelopmental condition (e.g. Autism, dyslexia, dyspraxia)	Details

Other professionals involved (e.g. CMHT, Psychology, Social Services)

A. Name

Profession

Contact details

Is this person in agreement with the referral? YES ☐ NO ☐

What are their expectations from the service?

B. Name

Profession

Contact details

Is this person in agreement with the referral? YES ☐ NO ☐

What are their expectations from the service?

Have referrals been made to other agencies / organisations? YES ☐ NO ☐

If so which?

Additional information:

Please use the space below to provide any other relevant information
e.g. current risks, access to support, what the person wishes to obtain from the assessment

Please send the completed referral to:

Service for Adults with ADHD, Manygates Clinic, Belle Isle Health Park, Portobello Rd, Wakefield, WF1 5PN or fax to 01924 360806.

For any queries when completing this referral please contact the team on 01924 316492/316490

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