ADHD pathway referral form

South West Yorkshire Partnership NHS Foundation Trust

Please use the Autism Pathway Referral Form for autism referrals

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.

Reason for referral

- ☐ Diagnostic assessment of ADHD
- ☐ Medication review for someone already diagnosed with adult ADHD
- ☐ Non-medication based interventions

Please note: The service is not commissioned to accept referrals for patients diagnosed in private practice or elsewhere under Right To Choose. If a person has moved to the area and is on established treatment for ADHD, please provide their diagnostic report and care plan which will be used to offer appropriate advice.

Date of referral

Referrer details

Name

Address

Telephone number

Designation

Details of person referred

Name

NHS number

Date of birth

Current address

Home telephone

Mobile telephone

With **all of us** in mind.

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

GP details

Name

Surgery address

Telephone number

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:

Adult ADHD Service, Manygates Clinic, Belle Isle Health Park, Portobello Rd WAKEFIELD WF1 5PN
or email ADHDandAutismService@swyt.nhs.uk

For any queries relating to this referral, please contact the team on 01924 316492

JOB NO 2677 JUN 22