

ADHD Referral Form

This referral form must be fully completed and signed by the child's G.P and/or Healthy Family Team Practitioner

Guidance

- Step 1. Parent and school to complete section A
- Step 2. Parent/carer to complete B, C, D
- Step 3. School to complete session C
- Step 4. Health Professional - GP **and/or** Healthy Family Team Practitioner to review referral, provide any further information to sections D & E and sign form.

**G.P – (child must be registered with a West Essex surgery):
or Healthy Family Team Practitioner**

Name of Referrer:	Role:
Signature:	Date:
Address:	Postcode:
Telephone no:	Email:

Section A

ADHD Questionnaires & School report

Referrer to ensure that parents/carers and school are supported to complete the questionnaires listed below and that they are all attached with the referral form. Please click on the link to our website where more guidance and the forms can be found.

[Attention Deficit Hyperactivity Disorder \(ADHD\) Nursing Service - Essex Child and Family Wellbeing Service \(essexfamilywellbeing.co.uk\)](http://essexfamilywellbeing.co.uk)

Failure to include all the screening assessment questionnaires and school report will result in rejection of the referral.

- Parent/carer SNAP and SDQ
- School SNAP, SDQ and school report

Section B (Parents to Complete)

Child / Young Person's Information

Child's name (including preferred name):		Date of birth:
NHS Number:		Sex:
Address:		
Postcode:		
Telephone no:		
Parent/Carer Name:	Address if different from above:	Parental Responsibility: Yes / No
Mobile no:		Email address:
Parent/Carer Name:	Address if different from above:	Parental Responsibility: Yes / No
Mobile no:		Email address:
Child's first language/preferred method of communication:	Parent's first language/preferred method of communication:	
Interpreter/Signer required (please state): Yes / No		

Social Care Information (Parent to complete)

Does your child / young person have a Child Protection Plan? YES / NO	Has your child ever been on a Child in Need or Child Protection Plan? YES / NO When:	Are you the child/young person's foster carer? YES / NO	Does your family currently have support from a social worker? YES / NO Name: Telephone:
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Child / Young Person’s Family and Social History

Nature of concerns

Please tell us when you first thought that your child might have ADHD (Attention, Deficit Hyperactivity, Disorder) and what made you think this was likely?

Family History

Please tell us about anyone in the family who has or is suspected to have learning difficulties, ADHD, Autism, mental health difficulties, developmental problems or language problems.

Comments:

Past Experiences

Please tell us about any significant, traumatic, or adverse events in your child’s life, which could possibly be relevant to your child’s emotional wellbeing and behaviour.

Comments:

SECTION C (Parent AND school to complete)

Please provide a full description of your child at home and in school setting below. Please continue on additional page if required.

Area of behaviour	Comments and examples
Please describe any concerns related to this child/young person’s focus and attention at home and at school. Please provide at least two examples from home and two from school	Home:

<p>(See guidance notes 1 A-H and 3C)</p>	<p>School/Setting:</p>
<p>Please describe any concerns related to this child/young person's impulsive behaviour at home and at school, from what age were these identified? Please provide at least two examples from home & from school (See guidance notes 2 A-D and 3C)</p>	<p>Home:</p>
	<p>School/setting:</p>
<p>Please describe any concerns related to this child/young person's hyperactive behaviour at home and at school, from what age were these identified? Please provide at least two examples from home & from school (See guidance notes 2 A-D and 3 C)</p>	<p>Home:</p>
	<p>School/setting:</p>
<p>Interacting with others e.g. Do they seek others to play or talk with?</p> <p>Do they have friends?</p> <p>Do they share with others?</p>	<p>Home:</p>
	<p>School/Setting:</p>

Play and imagination e.g., Describe your child's play and preferred activities.	Home:
	School/Setting:
Emotional wellbeing/behaviour e.g. Can your child calm down easily? Please give details Does your child self-harm/have a history of self-harming? If yes, please give details	Home:
	School/Setting:

Child's academic level Please highlight	Above expected level Expected level Below expected level
Any other information you think may be beneficial to the referral i.e. Is the child better behaved, worst behaved or about the same as their peers	
Teachers name and role	Teachers signature

Section D (Parents/GP/Healthy Family Practitioner to complete)

Child's Medical History

Current Health

Do you have any concerns about your child's general health? Please include any past operations, hospital admissions and treatment involved. Please give the name of the doctor/consultant, team and hospital.

Comments:

General Development: (Parent/School to complete)

Do you have any concerns about your child's general mood and/or behaviour?

Comments:

Please tell us about your child's sleeping patterns. Please include details of any sleep routines or methods to help manage sleep.

Comments:

Does your child have an awareness of danger and consequences?

Comments:

Do you have any concerns about your child's diet, appetite or eating behaviours?

Comments:

Section E (G.P. and/or HFT only)

Other G.P. medical information:

Please add any further medically relevant information.

Is there any other diagnosis being considered to explain current symptoms?

Additional Information:

Please tick below any other services who have been involved in the child / young person's support:

Audiologist <input type="checkbox"/>	Optician <input type="checkbox"/>	Health Visitor <input type="checkbox"/>	CAMHS (Child and Adolescent Mental Health Service) <input type="checkbox"/>	Educational psychologist <input type="checkbox"/>
Speech and Language Therapist <input type="checkbox"/>	Occupational Therapist <input type="checkbox"/>	Physiotherapist <input type="checkbox"/>	Paediatrician <input type="checkbox"/>	School nurse <input type="checkbox"/>
Children's Learning Disability Service (CLDS) <input type="checkbox"/>	Social Services <input type="checkbox"/>	Specialist teacher <input type="checkbox"/>	Other <input type="checkbox"/>	

Please attach any reports from the agencies stated above with this referral form

Consent:

The parent/carer consents to:

Tick

- Referral for an ADHD assessment
- The ADHD team obtaining information from other agencies including the school/education setting
- The ADHD team sharing information with other professionals
- The ADHD team observing their child in an educational setting if this is required
- Child attending a QB test at a clinic setting if this is required

Parent/Carer's name	Parent/carer's signature	Date:
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Thank you for your cooperation, please return to:

Florence Nightingale Child Development Centre,
 Minton Lane,
 Harlow.
 CM17 9TG.

Or by Email to: VCL.essexwest-harlowcdc@nhs.net

Please ensure you have included the following:

- Relevant screening assessments (SNAP and SDQ, both home & school)
- Fully completed referral form with signatures from Parent/Carer, Teacher, Referrer
- Any supporting reports/documents you think would be helpful to assist this referral

Commissioned by: