Referral Form to UCC Student Health requesting ADHD/ADD treatment for UCC Student.

For use only for students previously diagnosed by a **Consultant Psychiatrist** as having ADHD/ADD.

All sections must be completed in full. If any section is incomplete the form will not be processed and will be returned to the referring Doctor. All referrals must be signed by the referring Doctor and must be accompanied by a clinic stamp on this referral form.

Name of Patient	
Date of Birth	
Address	
Next of kin/ Name of person to provide Collateral history if required	
Name and address of referring Psychiatrist	

Date diagnosis of ADHD was made:	
Diagnosis:	ADD ☐ ADHD ☐
Diagnostic tools used to establish diagnosis	Connors ☐ DIVA ☐ CADDRA ☐ Other: please state____________________ Please note that screening tools such as the ASRS <u>are not sufficient</u> to establish a diagnosis
Evidence of impairment prior the age of 12 Evidence of impairment prior the age of 12 established through:	Yes ☐ School Reports ☐ Collateral history ☐ Other: please state__________
Comorbid diagnoses/Other Conditions	ASD ☐ Mood Disorder ☐ Dyspraxia ☐ Dyslexia ☐ Generalized anxiety disorder ☐ Panic Disorder☐ OCD ☐ Anorexia Nervosa ☐ Bulimia Nervosa ☐ Binge Eating Disorder☐ Psychosis ☐ Other_____________

Risk Assessment	Current deliberate self-harm ☐ History of deliberate self-harm ☐ Current suicide ideation ☐ History of suicide ideation ☐
Previous inpatient admission for Mental Health issue	Yes ☐ No ☐
Current alcohol Use	_________ units a week:
Current Cannabis use	Yes/ No. Frequency per week:
CBD/TCH/ vapes or other products	Yes/No. Specify which ______________ Frequency per week:
Current medication details Specify details of dose and frequency	Please list all current medications
Previous medication no longer used Specify reasons for discontinuation	
Medication Allergy	
Family Psychiatric History	ADHD ☐ Neurodevelopmental disorder ☐ ASD ☐ Mood disorder ☐ Addiction ☐ BPAD ☐
History of exercise syncope, undue breathlessness, and other cardiovascular symptoms?	Yes ☐ No ☐ Please give details_________________
ECG/Cardiology review is needed if:	History of congenital heart disease or previous cardiac surgery: Yes ☐ No ☐ History of sudden death in a first degree relative under 40 years: Yes ☐ N ☐ Shortness of breath on exertion compared to peers Fainting on exertion or in response to fright or noise: Yes ☐ No ☐ Palpitations: Yes ☐ No ☐ Chest pain suggestive of cardiac origin: Yes ☐ No ☐

<table>
<tr><td></td><td>Signs of heart failure: Yes ☐ No ☐
Murmur on auscultation: Yes ☐ No ☐
BP classified as hypertensive: Yes ☐ No ☐</td></tr>
<tr><td>Personal or Family Medical History</td><td><table><tr><td></td><td>Personal</td><td>Family</td></tr><tr><td>cardiac auscultation/murmurs?</td><td></td><td></td></tr><tr><td>family history of cardiac disease</td><td></td><td></td></tr><tr><td>current medication</td><td></td><td></td></tr></table></td></tr>
<tr><td>Physical examination completed</td><td>Yes ☐ No ☐

Heart rate __________

Blood pressure __________

Height ____________

Weight ___________

Details of any abnormal cardiac findings e.g. murmurs: ___________</td></tr>
<tr><td>Date that the patient was last assessed, and ongoing care need established</td><td>dd/mm/yyyy: ___________</td></tr>
<tr><td>I have established and recommend support for an ongoing care need in this student:

I understand that clinical care for ADHD management will remain with me until the patient has transferred care to another consultant psychiatrist.</td><td>Signed:

Signed:

Stamp of Consultant Psychiatrist
(Include Contact Details and Postal Address)</td></tr>
</table>

Post this completed form to:

UCC Mental Health Team, Student Health Department, 1 Brighton Villas, Western Road, Cork T12 V304