Referral Form to UCC Student Health requesting continuation of ADHD treatment for UCC Students

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

For use only for students previously diagnosed as having ADHD

Guidelines: UK Adult ADHD Network - Guidelines for ADHD Assessment (AQAS)

| • | Pre-Assessment (baseline) information  |
|---|--|
| • | A detailed account of presenting issues suggestive of ADHD (covering both childhood      |
|   | and adulthood)   |
| • | Developmental history (which may include a patient–written 'life story' or timeline)     |
| • | A review of school (or other relevant) reports - Informant input (i.e., partner, parent, |
|   | friend) of both a qualitative and quantitative nature                                    |
| • | Use of a semi–structured diagnostic interview  |
| • | A consideration of impairment  |
| • | Screening for mental and physical health comorbidity (including other                    |
|   | neurodevelopmental conditions and conditions that are commonly associated with           |
|   | ADHD)  |
| • | An assessment of cardiovascular status (including baseline blood pressure, pulse and     |
|   | weight) prior to initiating medication   |
| • | A screen for risk/safety issues  |
| • | A cross reference to the diagnostic criteria   |
| • | A discussion about treatment options (and other relevant information)                    |

All sections must be completed in full. 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</u> <u>sufficient</u> to establish a diagnosis |
| Evidence of impairment prior the age of 12?                     | Yes □   |
| Evidence of impairment prior the age of 12 established through: |   |

|   | School Reports □                           |
|---|--|
|   | Collateral history □                       |
|   | Other: please state                        |
| Comorbid diagnoses/Other Conditions       |  |
| -   |  |
|   |  |
|   |  |
|   |  |
| Risk Assessment                           | Current deliberate self-harm □             |
|   | History of deliberate self-harm □          |
|   | Current suicide ideation □                 |
|   | History of suicide ideation □              |
| Previous inpatient admission for Mental   | Yes □ No □                                 |
| Health issue                              | 103 11 110 11                              |
| Current alcohol Use ?                     | units a week:                              |
| Current Cannabis use ?                    | Yes/ No. Frequency per week:               |
| CBD/TCH/ vapes or other products?         |  |
| Current medication details                | Please list <u>all</u> current medications |
| Specify details of dose and frequency     |  |
|   |  |
|   |  |
|   |  |
| Previous medication no longer used        |  |
| Specify reasons for discontinuation       |  |
|   |  |
|   |  |
| Family Psychiatric History                | ADHD □                                     |
|   | Neurodevelopmental disorder □              |
|   | ASD □                                      |
|   | Mood disorder □                            |
|   | Addiction □                                |
|   | BPAD □                                     |
| Date that the patient was last assessed,  |  |
| and ongoing care need established         |  |
| I have established and recommend support  | Signed:                                    |
| for an ongoing care need in this student: |  |
|   |  |
|   |  |
| Stamp of Consultant Psychiatrist          |  |
| (Include Contact Details and Postal       | _  |
| Address)                                  |  |
|   |  |
|   |  |
|   |  |
|   |  |