

**ADHD Assessment**

**Referral Form**

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| **Guidance: Please read prior to completing the referral form**   * ADHD is a lifelong neurodevelopmental condition which has a significant and pervasive impact on a person’s functioning. * If you do not think concerns are sufficient at this time to prompt a referral, consider a period of ‘watchful waiting’ or contact the service to discuss concerns prior to referring. * It is important that a referring professional has discussed the implications of a diagnosis with the family and the child/young person (if appropriate). Is this the right time for referral? * Any referring professional must have observed the child before a referral can be made by them * **Please ensure that the consent to refer is explained to the parent / carer / young person giving consent for assessment and is read and understood before they sign it.** | |
| **Child/Young Person’s Details** | |
| **Name:** | **Date of birth:** |
| **Address:** | **Telephone number:**  **Home:**  **Mobile:** |
| **NHS Number:** | **Is the child/young person Looked After? YES/NO** |
| **Ethnicity:** | **Spoken language:**  **Is an interpreter needed?** Yes / No |
| **GP name and address:** | **GP Telephone number:** |
| **Referrer Details** | |
| **Name:**  **Contact number:**  **Contact email:** | **Contact address:**  **Signature:**  **Date of referral:** |
| **Consent to Refer** | |
| **Please discuss the process with the child/young person. Where they are able to decide for themselves whether the assessment should go ahead (or not), please ensure they are happy to proceed and (if they agree) please request their written consent below.**   * **Where Parent/Carer is consenting on child’s behalf**   What does the child understand about this assessment? (Please show relevant information)  Have they any worries or concerns regarding the process?   * **Where Child/Young Person is consenting for themselves**   Do you feel you understand the assessment process?  Have you any worries about what will happen?  To be completed by Parent/Carer or Child/Young Person ***[please read carefully and******delete sections in bold* *as appropriate*]**  I give my permission for **[my child / myself]** to be referred for an Assessment of ADHD which may include a referral to any of the following professionals: Educational Psychologist, Clinical Psychologist and Paediatrician.  I have been informed of the purpose of these referrals and understand what it involves.  I understand that a referral does not guarantee an assessment will be completed but it will be considered by ADHD Assessment Team.  I agree that the Team may seek and store information from other professionals (including medical or other health specialists) who are or may become involved to assist in assessment.  I also give permission for the Team to share/request relevant information and opinions about **[my child / myself]** with professionals involved. This could include Community Paediatricians, Speech and Language Therapists, Education Psychologists, Clinical Psychologists, and others as appropriate. I also give consent to receive correspondence via digital means (including SMS and email).  I understand that I can withdraw this consent at any time by informing the referrer above or by contacting the ADHD Assessment Team.  I understand that information will be retained for as long as is necessary to determine the appropriate course of action and that records will be maintained in line with the Humber NHS Teaching Foundation Trust Records Management Policy.  **Name of Parent/Carer or Child/Young Person (please write clearly)**  **Relationship to child (if required)**  **Signature consenting to referral**  **Date** | |
| **Information about the Child/Young Person** | |
| **Additional diagnoses** (e.g. Autism epilepsy, motor disorders, intellectual disability, complex language disorders or complex mental health disorders - please attach reports if available) | |
| **Do they have a physical, hearing, or visual impairment? YES/NO**  *If ‘YES’, please provide details:* | |
| **Does the child/young person take any medication? YES/NO**  *If ‘YES’, please provide details.* | |
| **School/college attended:**  **Contact details:**  **Do staff have any current, significant concerns?** YES / NO If yes, please provide details: | |
| **Are any other agencies involved with the child/young person?** (Please provide contact details and attach reports if relevant). | |
| **Thank you for completing this form.** | |

Please return complete forms to email: [hnf-tr.hullandeastridingneurodiversityservice@nhs.net](mailto:hnf-tr.hullandeastridingneurodiversityservice@nhs.net) **OR**

Neurodevelopment Team

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