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**REFERRAL TO THE ADHD SERVICE**

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| **Service User Details** |
| Name |  | DOB |  |
| Address |  | NHS number |  |
| Contact phone number |  |
| Ethnicity |  | Contact Email  |  |
| **Referrer Details** |
| Name |  | Phone |  |
| Address |  | Email Address |  |
| **GP details (if not referrer)** |
| Name |  | Phone |  |
| Address |  | Email Address |  |
| **Other professionals involved?** |
| 1 | Name |  | Service |  | Contact details |  |
| 2 | Name |  | Service |  | Contact details |  |
| 3 | Name |  | Service |  | Contact details |  |

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| **Survey** |
| Has the person consented to this referral? | Yes[x]  | No[ ]  |
| Reason for referral, ADHD presenting problems (extent and duration of difficulties) |  |
|  |  |
| Have referrals been made to other agencies or organisations to meet these needs? (We only assess and treat ADHD) | Yes[ ]  | No[x]  |
|  |  |

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| --- |
| **Developmental History:** |
|   |
| **Psychiatric History:** |
|  |
| **Risk Issues – self/others, including historical:** |
|  |
| **Current Alcohol or Illicit Substances:** |
|   |
| **Current Medication:** |
| None |

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| **The following documentation must be included with the referral form (please note that assessment will be delayed until this is supplied)** |
| Completed ASRS v1.1 | Yes[x]  | No[ ]  |
| Primary Care Patient Summary | Yes[ ]  | No[ ]  |
| Previous ADHD correspondence | Yes[ ]  | No[x]  |
| Other relevant reports | Yes[ ]  | No[x]  |
|  |
| Signature |  | Base |  |
| Printed name |  | Date |  |
| Phone |  |  |  |

**This referral will be screened by our service and you will be notified by letter of the outcome.**

**Please contact the service on tel: 01275 796262**

**Adult ADHD Service**

**Avon and Wiltshire NHS Mental Health Partnership NHS Trust**

**Petherton Resource Centre**

**3 Petherton Road**

**Hengrove**

**Bristol**

**BS14 9BP**

**Tel: 01275 796262**

**Fax: 01275 796205**

**Email:** **awp.specialisedadhdservices@nhs.net**