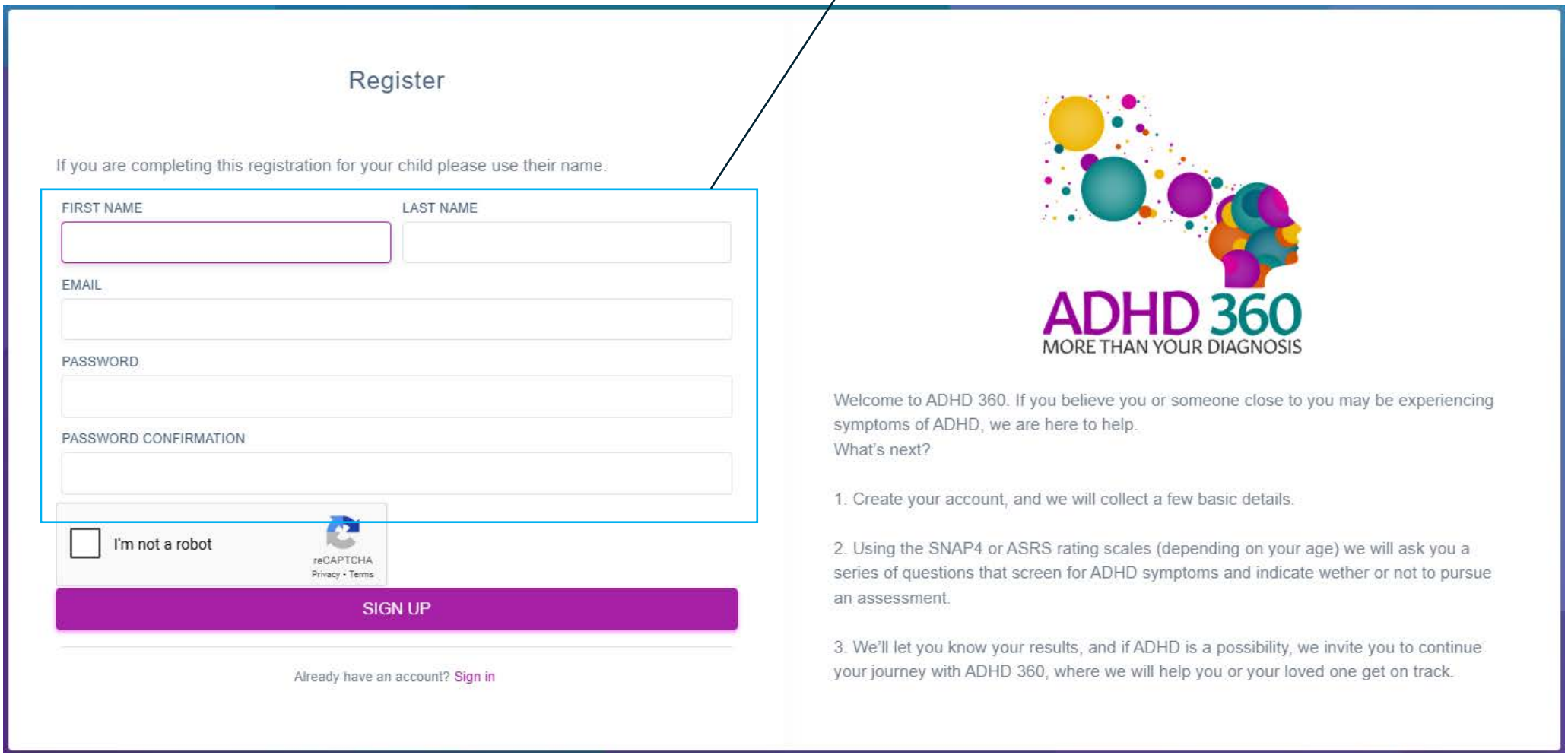
Register for an account on: https://app.adhd-360.com/users/sign_up

Provide YOUR details
ALL FIELDS ARE MANDATORY



Provide YOUR details
ALL FIELDS ARE MANDATORY

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Right to Choose Referral to ADHD 360

Referral for ADHD Assessment

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Date of referral:	**Please complete all sections and return by email to** RTCreferral@adhd-360.com
Patient's name: Home address: Date of birth: NHS No: Contact number for Patient: Contact email for Patient:	Name of GP: **Dr Anil Shah** GP practice address: **Stratford Health Centre** **123 The Grove, Stratford** **London E15 1EN** **The Forest Practice** **121 Woodgrange Road,** **Forest Gate** **London E7 0EP** **If patient already has diagnosis please state if this is NHS/Right to Choose, or Private:** When was diagnosis given? Who gave diagnosis?
Name, address & phone number of referrer:	Name, address & phone number of next of kin: does patient consent to sharing information with their next of kin?: Yes ☐ No ☐

Reason for referral – (Please give a comprehensive summary of current needs, please also include any current diagnosis and assessment of presenting risks and current issues with any supporting relevant reports and investigations.)

Please explain in detail -

Have the difficulties been evidence since childhood?
Yes ☐ No ☐

Has the presentation been unexplained by previous diagnosis?
Yes ☐ No ☐

Does the patient have any educational, psychological, or social impairment needs?
Yes ☐ No ☐

Your GP's name is **Dr Anil Shah**

Provide this address if you are a registered patient at **Stratford Health Centre**

Provide this address if you are a registered patient at **The Forest Practice**

Provide the date if know, if uknown leave it **BLANK**

Provide the clinician's name/department if know, if unknown leave it **BLANK**

If you are registered at **The Forest Practice**, please enter:
Dr Anil Shah, The Forest Practice, 121 Woodgrange Road, Forest Gate, London E7 0EP – 02034746510

OR

If you are registered at **Stratford Health Centre**, please enter:
Dr Anil Shah, Stratford Health Centre, 123 The Grove. Stratford, London E15 1EN

Please provide as much information as possible, including details about your social needs and the reasons why you believe you may have ADHD.

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Has the patient had any unmet prescribing needs?

Yes ☐ No ☐

Please provide as much information as possible, if you have answered **YES** to any of the questions

Please indicate type of Assessment /Intervention required –

Type the following:

Full ADHD 360 Assessment

PLEASE EMAIL ANY OTHER RELEVANT SUPPORTING DOCUMENTS LISTED BELOW TO ASSIST THIS REFERRAL – WITHOUT THIS DETAIL WE WILL RETURN THE REFERRAL

- ☐ **Patient Summary**
- ☐ **Current medication and last review date**
- ☐ **Previous engagement in Mental Health Services**
- ☐ **Previous diagnoses (excluding ADHD)**
- ☐ **Any reports undertaken by previous or current professionals**
- ☐ **Any previous ADHD diagnosis reports if appropriate**
- ☐ **Completed ASRS screening - completed by patient (attached to this form)**

Leave **BLANK** and do not make a selection:
This will be completed by the practice

Email: RTCrefererral@adhd-360.com

DO NOT EMAIL YOUR FORM TO THIS EMAIL ADDRESS

Email the completed form to Admin Manager at o.ciobanu@nhs.net

Please provide the following information regarding your local Integrated Care Board (ICB).
(*)Failure to provide the full details requested below will result in the referral being sent back for completion.

Name of current ICB (*)	NORTH EAST LONDON
Name of previous CCG (*)	NEWHAM
Name of commissioning contact/Mental Health Lead at the local ICB (if known)	RIKKE NEDERGAARD
Contact email and telephone of above contact (if known)	RIKKENEDERGAARD1@NHS.NET
Finance department contact information for billing at local ICB (if known) - this is generally held by your surgeries finance department/colleague	RIKKENEDERGAARD1@NHS.NET
Trade Shift Code / Payables Code (if known) - this is generally held by your surgeries finance department/colleague	

Provide the information as displayed

Please also review the accompanying PDF document thoroughly.

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Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

*Please answer **ALL** the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months.*
Please return this completed checklist to your GP along with this form, to discuss during your next appointment regarding your referral.

Patient name:
Completed by:
Date:

	Never	Rarely	Sometimes	Often	Very often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organisation?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Provide the requested information as accurately as possible

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Patient Waiting List Risk Assessment (PRA)

Please complete this form alongside your referral documents and provide this to your GP along with your referral form and ASRS screening. Your GP will review the contents and can provide additional support and signposting and send this to ADHD 360 with your referral.
If you do not feel comfortable with this, this form is also available for completion following receipt of your referral received and onboarding email from us.

A. Harm:

1. Have you ever hurt or injured yourself intentionally? Yes/ No
   If so please explain…
2. Have you ever had thoughts of hurting yourself or others? Yes / No
   If so please explain…
3. Have you ever acted on your thoughts? Yes/ No
   If so please explain…
4. If you answered yes to any of these questions; when did you last have those feelings/actions?

B. Self-medication:

1. Do you take any unprescribed medication, or recreational drugs? Yes/No
2. Do you regularly drink more than the recommended limit of alcohol? (14 units a week across 3 days) Yes/No

Thank you for completing this short questionnaire. Please return it to your GP as part of your referral documents, or once we have confirmed receipt of your referral you will be able to complete a similar questionnaire as part of your onboarding process.