

**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 –** **enquiries@adhd-360.com** |
| Patient’s name: Home address:Date of birth:NHS No:Contact number for Patient: Contact email for Patient: | Name of GP: GP practice address:**If patient already has diagnosis:**When was diagnosis given?Who gave diagnosis? |
| Name, address & phone number of referrer: | Name, address & phone number of next of kin:  |
| **Reason for referral** – **(**Please give a comprehensive summary of current needs, please also include current diagnosis and assessment of presenting risks and current issues with supporting relevant reports and investigations.)**Please explain in detail -**  Have the difficulties been evidence since childhood?Has the presentation been unexplained by previous diagnosis?Does the patient have any educational, psychological, or social impairment needs? Has the patient had any unmet prescribing needs?  |
| **Please indicate type of Assessment /Intervention required –**  |
| **\*\*\*PLEASE EMAIL ANY OTHER RELEVANT SUPPORTING DOCUMENTS TO ASSIST THIS REFERRAL – WITHOUT THIS DETAIL WE WILL RETURN THE REFERRAL\*\*\**** **Previous engagement in Mental Health Services**
* **Patient Summary**
* **Current medication and last review date**
* **Previous diagnosis excluding ADHD**
* **Any reports undertaken by previous or current professionals**
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**Email:** enquiries@adhd-360.com

Please provide the following information regarding your local Clinical Commissioning Group.

**Failure to provide the full details requested below will result in the referral being sent back for completion.**

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| Name of CCG  |  |
| CCG address  |  |
| Name of contact/ Mental Health Lead at the CCG for dialogue  |  |
| Contact email and telephone of above contact  |  |
| Finance department information for billing |  |
| Trade Shift Code / Payables Code Required |  |

Please also review the accompanying PDF document thoroughly.