Provincial ADHD Program Referral Form

Health PEI

University of Prince Edward Island
DRC Building Room 115
550 University Ave, Charlottetown, PE, C1A 4P3
T: 902-620-5296 F: 902-620-5302
Email: provincialadhdprogram@ihis.org

Name: ______________________________

PHN: ____________________

Date of Birth: ________________

Address: ______________________________

Phone #: ________________

Email: ____________________________

UPEI Student: Yes No

Date of Referral: ____________________

Referring Provider: ____________________

Preferred Pharmacy Name: ________________

Address: __________________________

Previous ADHD Diagnosis: Yes No

Date Diagnosed: ____________

Please send supporting documents with your referral (i.e. psychoeducational assessment).

Currently on ADHD Medication:Yes No

REASON FOR REFERRAL. CHECK ALL THAT APPLY:

- Organizational skill problems (poor time management, miss appointments, frequently late & unfinished projects)
- Erratic work/academic performance
- Anger control problems
- Family/marital problems
- Difficulty managing finances
- Addictions (shopping, drugs, alcohol, sex, overeating, exercising, video games, gambling)
- Problems with driving (speeding tickets, accidents, license revoked)
- Frequent accidents through recklessness or inattention
- Direct family member who has ADHD
- Had to reduce course load or difficulty completing assignments in school
- Low self-esteem or chronic under-achievement
- Difficulty maintaining self-regulating activities (household routines, sleep patterns)

Other:

1. ______________________________
2. ______________________________

COMORBID CONDITIONS. CHECK ALL THAT APPLY:

Anxiety	Bipolar Disorder	Obsessive Compulsive Disorder
Depression	Mood Disorders	Borderline Personality Disorder
Learning Disabilities	Autism Spectrum Disorder	Tic Disorder
Conduct Disorder	Cardiac Disorders	Substance Use

Other:

1. ______________________________
2. ______________________________

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Patient Name:

____

The following ADHD screening forms must be included with this referral. Please scroll down to fill in. If they are not included, the referral will not be accepted.

ASRS-version5 (patient to fill out)
ASRS-version1.1 (patient to fill out)

NOTE: If you have already had the following documents completed, do not repeat. Please fax to the number above.

Other materials to be provided if possible (Please check if they have been included):

Psychological evaluation
School Report cards
Other Relevant Medical Records: _______________________________________

Current Medications:

____

Past Medications:

____

Past Medical History:

1. _______________________________________

2. _______________________________________

Additional Pertinent Information:

1. _______________________________________

2. _______________________________________

3. _______________________________________

Reminder: The *Provincial ADHD Program* will NOT accept incoming referrals until all supporting documentation has been included. You, the referring physician/NP, will receive a "Missing Documentation" letter letting you know what is missing and needs to be sent in before it will be accepted. When / if all documentation has been included, you will receive a "Referral Acceptance" letter.

The *Provincial ADHD Program* will reach out to the patient directly with an appointment time. Please note that the wait times will vary depending on the demand at that time. Please notify the *Provincial ADHD Program* if the patient notifies you that they no longer need/want this appointment.

Physician / NP Signature: _______________________________________

Date: _______________________________

ADULT ADHD SELF-REPORT SCALE (ASRS-V1.1) SYMPTOM CHECKLIST

Patient: ______________________________ Date Completed: ____________

Please answer 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 give this completed checklist to your healthcare professional to discuss during your appointment.	Never	Rarely	Sometimes	Often	Very often
PART A					
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
How often do you have difficulty getting things in order when you have to do a task that requires organization?					
How often do you have problems remembering appointments or obligations?					
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					
PART B					
How often do you make careless mistakes when you have to work on a boring or difficult project?					
How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
How often do you misplace or have difficulty finding things at home or at work?					
How often are you distracted by activity or noise around you?					
How often do you leave your seat in meetings or in other situations in which you are expected to stay seated?					
How often do you feel restless or fidgety?					
How often do you have difficulty unwinding and relaxing when you have time to yourself?					
How often do you find yourself talking too much when you are in social situations?					
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 it themselves?					
How often do you have difficulty waiting your turn in situations when turn taking is required?					
How often do you interrupt others when they are busy?					

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Are you living with Adult ADHD?

The questions below can help you find out.

Many adults have been living with Adult Attention-Deficit/Hyperactivity Disorder (Adult ADHD) and don't recognize it. Why? Because its symptoms are often mistaken for a stressful life. If you've felt this type of frustration most of your life, you may have Adult ADHD – a condition your doctor can help diagnose and treat.

The following questionnaire can be used as a starting point to help you recognize the signs/symptoms of Adult ADHD but is not meant to replace consultation with a trained healthcare professional. **An accurate diagnosis can only be made through a clinical evaluation.** Regardless of the questionnaire results, if you have concerns about diagnosis and treatment of Adult ADHD, please discuss your concerns with your physician.

This Adult ADHD Self-Report Screening Scale for DSM-5 (ASRS-5) is intended for people aged 18 years or older.

Adult ADHD Self-Report Screening Scale

for DSM-5 (ASRS-5)

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from Composite International Diagnostic Interview for DSM-5 (CIDI-5.0)

© President and Fellows of Harvard College

Patient Name: **Date:**

Check the box that best describes how you have felt and conducted yourself over the past 6 months. Please give the completed questionnaire to your healthcare professional during your next appointment to discuss the results.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have difficulty concentrating on what people are saying to you even when they are speaking to you directly?					
2. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
3. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
4. 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?					
5. How often do you put things off until the last minute?					
6. How often do you depend on others to keep your life in order and attend to details?					