**FORM 1: Professional Referral Form - Please send completed forms and reports to**: [referral.lypft@nhs.net](mailto:referral.lypft@nhs.net)

Form 1 (Professional Referral Form) is completed by the referrer.

Form 2 (Self-Assessment Form by Service User) is completed by the service user.

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| **Reason for referral -**Tick one box to indicate the reason for the referral. |

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| **OPTION 1** | |
| **Diagnostic assessment needed.**  The service user requires a diagnostic assessment OR a diagnostic report cannot be provided (in which case we will need to confirm the diagnosis in the absence of a report). | **Action required:** Both Form 1 and Form 2 need to be completed and returned.  **What to expect following referral:**  Once both forms are returned, they will be triaged, and the GP and the service user informed of the decision and next steps. |

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| **OPTION 2** | |
| **Treatment or annual review / Shared Care needed.**  The service user requires ADHD treatment or annual review / Shared Care AND a diagnostic report can be provided. | **Action required**: Form 1 **AND** diagnostic report to be returned.  **What to expect following referral:**  Once Form 1 and the diagnostic report are returned, the report will be quality checked and the GP and the service user informed of the decision and next steps.  We encourage refers, where possible, to include supporting evidence for the reports such as feedback forms and interview notes. This may enable us to confirm the diagnosis where the report is not sufficient. |

**Referral exclusions:**

* No evidence of ADHD symptoms prior to the age of 12.
* The service user is not registered with a Leeds GP.
* The service user is not yet 18 years old.
* Incomplete referral form.

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| **Service user details** | | |
| Full Name |  | |
| Date of birth |  | |
| NHS Number |  | |
| Home address |  | |
| Does the service user consent to this referral? | Yes | No |

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| **GP Details** | | | |
| GP Practice Name |  | Email address |  |
| Practice Address |  | | |

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| **Referrer details** *(If different from GP details above)* | | | |
| Name |  | Telephone Number |  |
| Address |  | Email address |  |
| Date of referral |  | | |

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| **Shared Care** | | |
| Does the service user have a shared care agreement for ADHD treatment with another provider? | Yes | No |
| If yes, please outline the reasons for this referral (as care should be provided by the original provider): | | |

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| **Current ADHD Medication** | | |
| Is the service user currently prescribed ADHD medication? | Yes | No |
| If yes, please outline: | | |

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| **Psychiatric history** | |
| Please indicate if the service user has any of the listed conditions. | None  Autism  Intellectual disability  Psychosis / Bipolar disorder  Substance use disorder  Other (specify below): |

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| **Medical history** (If you are not the GP, please ensure this is confirmed by a medical professional) | |
| Please note and describe any physical health concerns | No significant medical history  Congenital heart disease  Current heart disease  Heart murmur  Glaucoma  Thyroid condition, please specify:  Epilepsy  Other (specify below): |

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| **Risk Information** | | |
| **If you feel that the service user is currently acutely unwell or at significant risk to themselves or others, then please refer to appropriate services.** | | |
| Are there significant concerns about the service user’s risk of self-harm or their harm to others? | Yes | No |
| If yes, then please describe: | | |
| Is the service user involved with other mental health / learning disability services? | Yes | No |
| If yes, then please describe: | | |
| Are there any safeguarding referrals (including dependent children or vulnerable persons) or social care involvement involving the service user? | Yes | No |
| If yes, then please describe: | | |

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| **Additional Information** |
| Please use this space for any relevant additional information or attach additional sheets as necessary. |