**Additional information:**
**Request to consider take over ADHD medication**
**(when child or young person has an ADHD diagnosis**
**and is already taking ADHD medication)**

Thank you for your time in completing this extra information. It is essential to help us understand the child/young person’s needs.

**What to do now**

1. Please complete this form and save it.
2. Return to the Berkshire Healthcare online referral form, complete it and upload this document when prompted. The form can be found here: <https://forms.berkshirehealthcare.nhs.uk/cypf/>
3. Please note, when you fill in the referral form it will prompt you to attach a copy of the support plan. **Please attach a copy of the ADHD assessment report instead** unless we did the ADHD assessment).
4. Please then email a copy of the ADHD medication letter/s to: CYPADHDandAutismTriage@berkshire.nhs.uk

**Please note, we will not be able to proceed with the request for help unless you have uploaded this additional information form and the ADHD assessment report and provided the most recent medication letter/s.**

If helpful, please look at the information on our website relating to private assessments

[cypf.berkshirehealthcare.nhs.uk/adhd](https://cypf.berkshirehealthcare.nhs.uk/adhd/)

|  |
| --- |
| **Details of child/young person** |
| First Name |  | Date of birth |  |
| Last name  |  | Age in years and months (eg 8y 6m) |  |
| Usual name (if different to first name)  |  |

|  |
| --- |
| **1. Information about ADHD diagnosis** |
| When was the ADHD diagnosis made?*Please provide exact date if possible*  |  |
| **Who made the diagnosis of ADHD?** | [ ]  Berkshire Healthcare ADHD Team[ ]  Berkshire Healthcare CAMHS [ ]  Other NHS provider – please tell us which one Click or tap here to enter text.[ ]  Private provider – please tell us which one Click or tap here to enter text. |
| If diagnosis was not made by Berkshire Healthcare please confirm you have emailed the full assessment report and uploaded the most recent ADHD medication letter. | [ ]  **YES** ***Please note that we are unable to accept a referral without the assessment report unless we provided the assessment.***  |

[ ]

|  |
| --- |
| **2. Information about CURRENT ADHD medication**  |
| Please tell us the name of the ADHD medication, the doses/strengths and how often they take it Please write the name as it appears on the packet Eg Medikinet XL, 20mg, twice a day | **Name of medication:****Dose/strength of medication:****How many times a day:** |
| Is the young person taking any other medication?[ ]  Yes - please complete the table opposite [ ]  No | **Name of medication/s** | **Dose/strength of medication**  | **How many times a day**  |
|  |  |  |
|  |  |  |
|  |  |  |
| Please upload letter/s relating to the ADHD medication/reviews. ***Please note that we are unable to accept a referral without this information.***  | Confirm medication letter/s uploaded[ ]  **YES**  |
| Who is currently prescribing the ADHD medication? | [ ]  NHS provider - please tell us which one Click or tap here to enter text.[ ]  Private provider – please tell us which one Click or tap here to enter text.[ ]  GP |
| Who is currently reviewing the ADHD medication? (offering appointments to discuss how well treatment is working, side effects etc)  | [ ]  NHS provider - please tell us which one Click or tap here to enter text.[ ]  Private provider – please tell us which one Click or tap here to enter text.[ ]  GP |
| Who is currently monitoring height, weight, blood pressure and pulse? | [ ]  NHS provider - please tell us which one Click or tap here to enter text.[ ]  Private provider – please tell us which one Click or tap here to enter text.[ ]  GP[ ]  Other – please tell us who Click or tap here to enter text. |
| Is the young person stable on medication (ie the right dose has been established with no further change planned at this point). ***Please note we are unable to take over care mid-way through starting treatment unless in exceptional circumstances e.g. a child has been taken into care outside the area they live in.*** | [ ]  Yes [ ]  No [ ]  Other – please describe Click or tap here to enter text. |

**Thank you very much for completing the form – this should provide all the information we need to decide on the best way to help child or young person.**

**You can now return this form by uploading it with the** [**online referral form**](https://forms.berkshirehealthcare.nhs.uk/cypf/)**.**

**We would love to hear from you**

We would be very grateful if you could spare a few minutes to tell us about your experience of the referral process. This helps us know where things are going well and where we might have more work to do.

Please fill in this short form to give us your feedback and ideas: <https://forms.office.com/e/zysA3fzpeu>