



DGS Health Adult ADHD Right to Choose Referral Form

Section 1 – Patient Details

NHS Number

Full Name

DOB

Address

Telephone

Email

Preferred contact method ☐ Phone ☐ Text ☐ Email

GP Practice

Registered GP

Section 2 – Eligibility Checklist

- ☐ Patient is aged 18 years or over
- ☐ Patient is registered with an NHS GP in England
- ☐ Patient understands this is a Right to Choose referral
- ☐ Patient has agreed to referral
- ☐ Patient has capacity to consent
- ☐ NHS number verified

Following Kent & Medway ICB guidelines the following patients will be prioritised:

Please tick one or more below: Referrals will not be accepted unless one is ticked

- ☐ Individuals with evidence of safeguarding concerns, including family court proceedings, child or adult protection concerns, individual vulnerability, abuse or neglect.
- ☐ Individuals involved in current criminal justice proceedings where ADHD symptoms may be relevant.
- ☐ Transition referrals from children to adult services.
- ☐ Individuals with escalating mental health needs, clinically identified by an appropriately trained professional as being exacerbated by ADHD symptoms and where ADHD medication may be appropriate to reduce or manage clinical risk.
- ☐ None of the above

Section 3 – Reason for Referral

Please briefly describe why ADHD assessment is being requested.

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Presenting symptoms

Tick all that apply

- ☐ Difficulty concentrating
- ☐ Poor organisation
- ☐ Easily distracted
- ☐ Forgetfulness
- ☐ Hyperactivity
- ☐ Restlessness
- ☐ Impulsivity
- ☐ Emotional dysregulation
- ☐ Difficulty maintaining employment
- ☐ Educational difficulties
- ☐ Relationship difficulties
- ☐ Other

Section 4 – Functional Impact

Tick all that apply.

Education

- ☐ Significant difficulties
- ☐ Moderate difficulties
- ☐ No difficulties

Employment

- ☐ Significant impact
- ☐ Moderate impact
- ☐ No impact

Relationships

- ☐ Significant impact
- ☐ Moderate impact
- ☐ No impact

Daily living

- ☐ Significant impact
- ☐ Moderate impact
- ☐ No impact

Brief comments

Section 5 – Mental Health History

Current diagnoses



- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Personality Disorder
- ☐ Autism
- ☐ PTSD
- ☐ OCD
- ☐ Eating Disorder
- ☐ Psychosis
- ☐ Learning Disability
- ☐ None known
- Other

Section 6 – Risk Assessment

Safeguarding concerns

- ☐ No
- ☐ Yes

If Yes please provide details

Section 7 – Physical Health

Weight _____

BMI _____

Blood Pressure _____

Pulse _____

Relevant medical conditions

Section 8 – Medication

Current medication

Any previous ADHD medication?

- ☐ No
- ☐ Yes

Details

Drug allergies

Section 9 – Substance Use

Alcohol

- ☐ None



- ☐ Low risk
- ☐ Hazardous

Drug use

- ☐ None
- ☐ Cannabis
- ☐ Cocaine
- ☐ Opiates
- ☐ Other

Smoking

- ☐ No
- ☐ Yes

Section 10 – Supporting Evidence

Please attach where available

- Childhood Scale
- Childhood Informant Scale (with instructions re who should complete it)
- Barkley Adult ADHD Scale

Section 11 – Exclusions

Please indicate if any of the following apply.

- ☐ Acute psychosis
- ☐ Immediate crisis requiring secondary mental health care
- ☐ Significant cognitive impairment preventing assessment
- ☐ Current inpatient mental health admission
- ☐ None of the above

Section 13 – Consent

I confirm:

- ☐ I have discussed this referral with the patient.
- ☐ The patient understands this is a Right to Choose referral.
- ☐ The patient consents to information sharing.
- ☐ The patient understands that treatment may include medication if clinically appropriate.

Date referral discussed with patient:

Section 14 – Referring Clinician

Name

Role

Practice

Email



Telephone

Date

Triage (Provider Use Only)

Date received

Referral complete ☐ Yes ☐ No

Accepted ☐ Yes ☐ No

Further information requested ☐ Yes ☐ No

Urgent review required ☐ Yes ☐ No

Clinician

Mandatory Attachments

The referral checklist should include:

☐ GP Summary (last 2 years)

☐ Current medication list

☐ Relevant mental health history

☐ Recent observations (BP, pulse, height, weight)

☐ Risk information