ADHD Pre-Assessment Patient Questionnaire

Please complete all sections before returning this questionnaire.
The information you provide will assist the clinical team in preparing for your ADHD assessment.

Patient Details

Full Name:

Date of Birth: _____/ _____/ _____

NHS Number (if known):

Address:

Postcode:

Telephone Number: Email Address:

Marriage and civil Partnership: Yes ☐ ☐ No

Race/Ethnicity:

Religion/Belief:

Reason for Referral (Please select one option)

1. For a new patient diagnostic assessment ☐
2. To restart, titrate or change of medication ☐
3. To transfer care to a new ADHD provider ☐

Communication Preferences

Do you consent to being contacted by email?

☐ Yes ☐ No

Do you consent to being contacted by mobile phone (calls and/or text messages)?

☐ Yes ☐ No

Do you consent to us accessing relevant healthcare records from services involved in your care (for example, your GP, Mental Health Services, or Drug and Alcohol Services)?

☐ Yes ☐ No

Accessibility and Additional Support

Do you require any reasonable adjustments or additional support to complete online questionnaires or attend appointments?

☐ Yes ☐ No

If yes, please provide details:

Language and Communication

Preferred spoken language:

Do you require an interpreter?

☐ Yes ☐ No

If yes, please specify the language required:

Tick ANY that apply and provide a brief explanation

☐ **Postnatal (within 12 months) with existing ADHD diagnosis and previously prescribed medication**

Brief explanation:

☐ **Veteran or armed service leaver**

Brief explanation:

☐ **Recently released from prison (within 6 months)**

Brief explanation:

☐ **ADHD already diagnosed AND recent mental health inpatient discharge (within 6 months)**

Brief explanation:

☐ **Open child protection plan AND clear concern ADHD is contributing to current risk**

Brief explanation:

Is there anything else you would like us to know before your assessment?

Declaration

I confirm that the information I have provided is accurate and complete to the best of my knowledge.

Signature:

Date: _____/ _____/ _____

Please return completed form via email to: bedminsterfamilypractice@nhs.net