Patient ADHD and/or ASD Referral Questionnaire

Right to Choose Provider you Have Selected:

PART 1 (complete for all referrals)
What are the symptoms, problems or experiences that lead you to suspect that you may have ADHD and/or ASD?
How do these symptoms impact on your life (e.g. education/work/home)?
Do you have a family history of ADHD and/or ASD? (if yes, who has this diagnosis?)

PART 2 (complete for ADHD referrals only)	
Please visit the ADHD UK website using the following link and complete the ADHD self-assessment. https://adhduk.co.uk/adult-adhd-screening-survey/	
The self-assessment will give you two scores (part A score and part B score). Please record your scores below.	
Part A Score:	
Part B Score:	

Patient Declaration:

By submitting this form, I confirm I have read the guidance associated with this referral document and I consent to the referral to the RTC provider named above. I am happy for my GP to email this along with a summary of my medical records to the RTC provider.

Patient name:

Patient signature:

Date: