

Provincial ADHD Program Referral Form

University of Prince Edward Island
DRC Building Room 115
550 University Ave, Charlottetown, PE, C1A 4P3
T: 902-620-5296 F: 902-620-5302
Email: provincialadhdprogram@upei.ca

Name: _____
PHN: _____
Date of Birth: _____
Address: _____
Phone #: _____
Email: _____
UPEI Student: Yes No

Date of Referral: _____
Referring Provider: _____
Preferred Pharmacy Name: _____
Address: _____
Previous ADHD Diagnosis: Yes No
Date Diagnosed: _____
Please send supporting documents with your referral (i.e. psychoeducational assessment).
Currently on ADHD Medication: Yes No

REASON FOR REFERRAL. CHECK ALL THAT APPLY:

- | | |
|--|--|
| Organizational skill problems (poor time management, miss appointments, frequently late & unfinished projects) | |
| Erratic work/academic performance | Problems with driving (speeding tickets, accidents, license revoked) |
| Anger control problems | Frequent accidents through recklessness or inattention |
| Family/marital problems | Direct family member who has ADHD |
| Difficulty managing finances | Had to reduce course load or difficulty completing assignments in school |
| Addictions (shopping, drugs, alcohol, sex, overeating, exercising, video games, gambling) | Low self-esteem or chronic under-achievement |
| Difficulty maintaining self-regulating activities (household routines, sleep patterns) | |

Other:

1. _____
2. _____

COMORBID CONDITIONS. CHECK ALL THAT APPLY:

- | | | |
|-----------------------|--------------------------|---------------------------------|
| Anxiety | Bipolar Disorder | Obsessive Compulsive Disorder |
| Depression | Mood Disorders | Borderline Personality Disorder |
| Learning Disabilities | Autism Spectrum Disorder | Tic Disorder |
| Conduct Disorder | Cardiac Disorders | Substance Use |

Other:

1. _____
2. _____

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Patient Name:

The following ADHD screening forms must be included with this referral. Please scroll down to fill in. If they are not included, the referral will not be accepted.

ASRS-version5 (patient to fill out)
ASRS-version1.1 (patient to fill out)

NOTE: If you have already had the following documents completed, do not repeat. Please fax to the number above.

Other materials to be provided if possible (Please check if they have been included):

Psychological evaluation
School Report cards

Other Relevant Medical Records: _____

Current Medications:

Past Medications:

Past Medical History:

1.

2.

Additional Pertinent Information:

1.

2.

3.

Reminder: The *Provincial ADHD Program* will NOT accept incoming referrals until all supporting documentation has been included. You, the referring physician/NP, will receive a "Missing Documentation" letter letting you know what is missing and needs to be sent in before it will be accepted. When / if all documentation has been included, you will receive a "Referral Acceptance" letter.

The *Provincial ADHD Program* will reach out to the patient directly with an appointment time. Please note that the wait times will vary depending on the demand at that time. Please notify the *Provincial ADHD Program* if the patient notifies you that they no longer need/want this appointment.

Physician / NP Signature:

Date:

ADULT ADHD SELF-REPORT SCALE (ASRS-V1.1) SYMPTOM CHECKLIST

Patient: _____ Date Completed: _____

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during your appointment.	Never	Rarely	Sometimes	Often	Very often
PART A					
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
How often do you have difficulty getting things in order when you have to do a task that requires organization?					
How often do you have problems remembering appointments or obligations?					
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					
PART B					
How often do you make careless mistakes when you have to work on a boring or difficult project?					
How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
How often do you misplace or have difficulty finding things at home or at work?					
How often are you distracted by activity or noise around you?					
How often do you leave your seat in meetings or in other situations in which you are expected to stay seated?					
How often do you feel restless or fidgety?					
How often do you have difficulty unwinding and relaxing when you have time to yourself?					
How often do you find yourself talking too much when you are in social situations?					
When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish it themselves?					
How often do you have difficulty waiting your turn in situations when turn taking is required?					
How often do you interrupt others when they are busy?					

Many adults have been living with Adult Attention-Deficit/Hyperactivity Disorder (Adult ADHD) and don't recognize it. Why? Because its symptoms are often mistaken for a stressful life. If you've felt this type of frustration most of your life, you may have Adult ADHD – a condition your doctor can help diagnose and treat.

The following questionnaire can be used as a starting point to help you recognize the signs/symptoms of Adult ADHD but is not meant to replace consultation with a trained healthcare professional. **An accurate diagnosis can only be made through a clinical evaluation.** Regardless of the questionnaire results, if you have concerns about diagnosis and treatment of Adult ADHD, please discuss your concerns with your physician.

This Adult ADHD Self-Report Screening Scale for DSM-5 (ASRS-5) is intended for people aged 18 years or older.

Adult ADHD Self-Report Screening Scale
for DSM-5 (ASRS-5)
 © New York University and President and Fellows of Harvard College
from Composite International Diagnostic Interview for DSM-5 (CIDI-5.0)
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Patient Name: _____ Date: _____

Patient Name: _____ Date: _____

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have difficulty concentrating on what people are saying to you even when they are speaking to you directly?					
2. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
3. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
4. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to before they can finish them themselves?					
5. How often do you put things off until the last minute?					
6. How often do you depend on others to keep your life in order and attend to details?					

- | | Never | Rarely | Sometimes | Often | Very Often |
|---|-------|--------|-----------|-------|------------|
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