Adult ADHD/Autism Referral Form

Please note that we are only able to accept referrals for patients who are aged 17 years and 6 months or above, under Right to Choose.

Additional guidance on making an appropriate referral can be found **here**

Referral for (***Mandatory please check as appropriate***)**:**		
☐ADHD	☐Autism	☐ADHD & Autism
Does the patient have an existing diagnosis of ADHD	☐Yes	☐No

Patient details (***Mandatory***)		
Title:	First name:	Surname:
Preferred name:	Date of birth:	NHS Number:
Contact information (***Mandatory***)		
Mobile number:	Email address:	
Patient postal address (If patient is homeless, please provide a CO address) (***Mandatory***)		

GP Details (***Mandatory***)	
GP Practice (Organisation Full Adress Stacked):	GP Practice contact information (Telephone number and email address):
ODS Code:	ICB:
Name of referrer:	

Reason for referral (***Mandatory***):
Please include clinical rationale for the referral to Psychiatry UK
Medical History (***Mandatory***):

Please insert problems and medications list here OR attach a summary care record when emailing

Risks & Safeguarding:		
☐Suicide	☐Self-harm	☐Self-neglect
☐Substance misuse	☐Risk from others	☐Risk to others
☐Child protection	☐CMHT involvement	
If any of the above apply, please provide further detail or corresponding letters.		

Additional information/needs:
Please specify here if a patient has any additional requirements, example: Language translation service (please specify the language required) or British sign language interpreter

Consent	
If the referred patient requires assistance with their medical care whilst at Psychiatry UK and wishes to give consent for someone to liaise with Psychiatry UK on their behalf, please provide the below details:	
Name:	Relationship to patient:
Contact information:	

Shared Care (*Mandatory*):	
Please indicate whether you will accept Shared Care for NHS RTC referrals if the patient is diagnosed and successfully completes the titration pathway for ADHD. A full copy of the agreement will be provided once the patient is stabilised on their medication. Note: Our Shared Care Agreement is for adult patients aged 18+. As part of the agreement, we will provide annual reviews which the patient must attend for their GP to continue prescribing.	
☐Yes	☐No

Referrer sign off *Must be by a GP, ANP or ACP (Mandatory))*:	
Referrer name: Signature:	Date:

Send completed referral forms to:

RTC-referrals@psychiatry-uk.com