**YOUTH AND ADULT COMPLEX ATTENTIONAL DISORDERS SERVICE (YACADS)**

**Client Referral Form**

***CONFIDENTIAL***

**Please complete form electronically & return via**

**fax to 9328 5911 (Attention: YACADS) OR via email to YACADS@health.wa.gov.au**

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| **CLIENT’S DETAILS:**  First Name(s):  Surname:  DoB:  UMRN:  Mobile Phone:  Home Phone:  Email:  Address:  Housing Status: Stable  / At Risk  Is Client a Parent? Yes  / No  If yes to being a parent:  Children Live at Home? Yes  / No | Gender at Birth:  Gender Identity:  Preferred Pronouns:  Primary Language:  Secondary Language:  Interpreter Needed? Yes  / No  **Please tick** **at least one box** to indicate the client’s ATSI status:  Aboriginal  Torres Strait Islander  Neither Aboriginal nor Torres Strait Islander |
| **REFERRER’S DETAILS:**  Name:       Position:  Referral Date:       Contact Number:  Community Mental Health Service (CMHS):  CMHS Postal Address:  Contact Email:  Consultant Name (if applicable): | |
| **YACADS Referral Criteria (Client must meet criteria for acceptance to service)**  Client is currently case managed by Community Treatment Team (NOT Acute Treatment Team) at a Youth or Adult Community Mental Health Service (includes Headspace Early Psychosis Program).  ASRS Completed (to indicate minimum severity requirement) – see page 6 of this form  **Referrer’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **PLEASE READ AND ACKNOWLEDGE**  YACADS is primarily an assessment service for ADHD. If deemed appropriate, clients may be offered a trial of stimulant medication following assessment and diagnosis with ADHD. As per the Schedule 8 medicines prescribing code, unless approved by the Chief Executive Officer/ Stimulant Assessment Panel, clients are not eligible for stimulant prescribing if they:   * have a history of stimulant induced psychosis * have a history of psychosis or bipolar disorder * have a history of substance abuse, diversion or misuse of drugs of addiction or Schedule 9 poisons within the previous 5 years; * have a record of drug dependence or oversupply; or * are a current Community Program for Opioid Pharmacotherapy (CPOP) participant.   I have read, understood, and discussed the above information with the client.  **Referrer’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |

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| **REFERRAL BACKGROUND:**  Presenting problems (including current symptoms of ADHD, duration, frequency, and impact on functioning):    Please list any previous ADHD diagnoses and treatments, including dates and names of treating Paediatrician/Psychiatrist where possible:    Other Mental Health condition(s), including alcohol/substance misuse (current and previous), Psychosis, history of hospital admissions, prior risk/self-harm issues etc:  **Past and/or current Substance use** (specify type of substance and whether previous or current use and misuse)    What is the specific referral request or question(s)?    If client already has diagnosis of ADHD, please advise reason for review of ADHD diagnosis.    How will the assessment help with the client’s management (i.e., goals for assessment)? |

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| **PAST NEUROLOGICAL/MEDICAL/PSYCHOLOGICAL HISTORY AND TREATMENT:**  (As above, please also attach any previous medical, psychological, radiological etc reports) |
| **EDUCATIONAL/OCCUPATIONAL HISTORY:**  (As above, please also attach any previous school psychologist/teacher reports) |
| **CURRENT MEDICATION REGIME AND MEDICAL INVESTIGATIONS:**  (As above, please also attach any relevant neurological/medical/psychological reports)  Current medications, including current dose and length of use:    Any previous medications, including when started and when/why stopped:    Previous or upcoming medical investigations and their results: |

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| **CURRENT AND PREVIOUS AGENCY/HEALTH PERSONNEL INVOLVEMENT (incl. GP):**  General Practitioner:       Contact Number:  Practice Name:       Email:  Other Professional:       Contact Number:  Practice Name:       Email:  Other Professional:       Contact Number:  Practice Name:       Email:  Are current agencies aware of this referral?  Would you like correspondence from YACADS to be sent to their General practitioner?  Yes  / No |
| **NEXT OF KIN AND CARERS’ DETAILS:**  Surname:       First Name(s):  Mobile Number:       Home Number:  Address:       Relationship to Client:  Surname:       First Name(s):  Mobile Number:       Home Number:  Address:       Relationship to Client: |
| **PLEASE COMPLETE THE REFERRER TICKLIST TO COMPLETE THE REFERRAL:**  School reports (ideally primary school) attached or:  reason that these are unavailable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relevant medical/diagnostic reports attached or:  reason that these are unavailable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relevant allied health reports (e.g., psychology, speech pathology) or:  reason that these are unavailable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signed consent for exchange of information between YACADS and all relevant third parties (i.e. GP, Next of Kin, previous prescribers etc; page 7)  Would you like correspondence from YACADS to be sent to their Next of Kin/ Carer?  **Referrer’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

If you would like to discuss a potential referral, please phone YACADS on (08) 9227 4300 during operating hours of 8:30 am to 4:30 pm Monday to Friday.

**Please return this form via:**

Fax to: (08) 9328 5911

Email to: [YACADS@health.wa.gov.au](mailto:YACADS@health.wa.gov.au)

Post to:

Youth and Adult Complex Attentional Disorders Service (YACADS)

223 James Street

NORTHBRIDGE, WA 6003

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

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.

Patient Name Today’s Date

|  | Never | Rarely | Sometimes | Often | Very  Often |
| --- | --- | --- | --- | --- | --- |
| 1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done? |  |  |  |  |  |
| 2. How often do you have difficulty getting things in order when you have to do a task that requires organization? |  |  |  |  |  |
| 3. How often do you have problems remembering appointments or obligations? |  |  |  |  |  |
| 4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started? |  |  |  |  |  |
| 5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time? |  |  |  |  |  |
| 6. How often do you feel overly active and compelled to do things, like you were driven by a motor? |  |  |  |  |  |
| 7. How often do you make careless mistakes when you have to work on a boring or difficult project? |  |  |  |  |  |
| 8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work? |  |  |  |  |  |
| 9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly? |  |  |  |  |  |
| 10. How often do you misplace or have difficulty finding things at home or at work? |  |  |  |  |  |
| 11. How often are you distracted by activity or noise around you? |  |  |  |  |  |
| 12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated? |  |  |  |  |  |
| 13. How often do you feel restless or fidgety? |  |  |  |  |  |
| 14. How often do you have difficulty unwinding and relaxing when you have time to yourself? |  |  |  |  |  |
| 15. How often do you find yourself talking too much when you are in social situations? |  |  |  |  |  |
| 16. 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? |  |  |  |  |  |
| 17. How often do you have difficulty waiting your turn in situations when turn taking is required? |  |  |  |  |  |
| 18. How often do you interrupt others when they are busy? |  |  |  |  |  |

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| **YACADS – CONSENT FORM** YACADSConsent Form | Surname: ………………………… UMRN: …………………Forename: ……………………………………………………Address: …………………………………………………………………………………………………………………………Sex: …………..……….. D.O.B. …………………………… |
| **AUTHORISATION TO RELEASE AND EXCHANGE INFORMATION** | |
| I (Full name),\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hereby authorise the **Youth and Adult Complex Attentional Disorders Service (YACADS)** to release and/or request information (specified below, tick indicates approval) from the following individuals and/or professional agencies nominated below who are involved in my care.   |  |  |  |  | | --- | --- | --- | --- | | **Name/Organisation** | **Specific instructions** | **Release information** | **Request Information** | |  |  | □ | □ | |  |  | □ | □ | |  |  | □ | □ | |  |  | □ | □ |   This consent form is valid for the duration of my current period of care with the service. I understand that I can withdraw or vary my consent at any time.  Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If the patient does not have capacity to sign:  Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |