VCH ADULT ADHD REFERRAL

Community Mental Health Services
HOpe Centre
1337 St Andrews Ave
North Vancouver V7L0B8
604.984.5000 FX 604.983.6073
ADHDAdultClinic@vch.ca

CLIENT _____ DOB (m/d/y) _____ PHN _____

Address_____City _____ Home_____

Cell _____ Work _____Email _____

REFERRING MD _____ MSP_____

Phone_____ Fax _____ Email _____

REFERRAL REASON (Indicate one primary reason)

___Assessment for ADHD
____ADHD Re-Assessment
___Medication readjustment
___Psycho education CBT Group

___**Referring physician is aware client will return to them for ongoing management, within a collaborative care model**

HISTORY

__ Positive Psychiatric History (Provide assessment and diagnosis information)

__ Recent or remote emotional and/or physical stress or trauma

__ Substance use recent/history (Please provide context of use)

MEDICAL

Medications

Guidelines for ADHD require physical examination and medical history within the last 6 mo, to r/o organic causes of ADHD-like symptoms.

Date completed _____ Done by _____

___ Positive Cardiac History (Attach current treatment and diagnostic information)

___ Chronic Medical Conditions (please list)

DATE _____ PHYSICIAN SIGNATURE_____