ASD or ADHD PATIENT QUESTIONNAIRE (ADULTS & CHILDREN)

Patient name:
DOB:
School attended by child:

Date of questionnaire completion:

Right To Choose Provider Of Choice:

PART 1 (patient to complete for all referrals)
What are the symptoms, problems or experiences that lead you to suspect that you may have ADHD and/or ASD? **If you or the patient feels distressed with thoughts of self-harm as a result of these symptoms, please do not complete this form and contact your GP or 111 *immediately.***
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 - Supporting Information
You will need to provide completed questionnaires to support your type of RTC referral (for adult and children, and both ASD and ADHD).

Please refer to your RTC provider of choice website and complete the relevant questionnaires, **save your results as a PDF copy and email back to us along with this questionnaire (see below).**

For children, it is highly recommended that you have a letter/report from school to support the referral.

Patient/Guardian Declaration:

By submitting this form, I confirm I have read the guidance associated with this referral document [(ADVICE TO PATIENTS BEFORE REFERRING VIA RIGHT TO CHOOSE (RTC)] 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:

OR

Patient/Guardian name:
Relation to patient:

NEXT STEPS:
Please email this questionnaire and PDF of your supporting questionnaires to the secretarial team on
bobicb-ox.emg.secretaries@nhs.net

We will send confirmation once your referral is made.