Psych Connect Pty Ltd
Psychology Services
Therapy for Individuals, Couples & Families

New Referral Form – Adult ADHD

Client Information

Date:	

Client Name:					
Email:					
Mobile Phone:				Home Phone:	
Date of Birth:		Age:		Gender:	
Occupation/employment status:				GP details:	

Additional Information	
What are your main concerns, and how long have these difficulties lasted?	Brief descriptions:
Any previous diagnosis? (check all that apply)	**A):** ☐ Depression ☐ Anxiety ☐ Bipolar ☐ Psychosis ☐ ASD ☐ Learning difficulties ☐ Other: _____ **B)**: Are you currently receiving treatment or support for any conditions above? ☐ No ☐ Yes, give details
Are you currently experiencing any of these difficulties? (check all that apply)	☐ Substance issues ☐ Major trauma/crisis (past 6 months) ☐ Sleep disorder
Medical conditions affecting concentration/energy?	☐ No ☐ Yes, give brief details
Current medications?	☐ No ☐ Yes
History of head injury/concussion?	☐ No ☐ Yes, give brief information

Family history of ADHD diagnosis?	☐ No ☐ Yes - relationship:
Are previous psychological or health practitioner reports available?	☐ No ☐ Yes, please send a copy of these reports before your initial appointment.
Will assessment results be used for? (check all that apply)	☐ Personal/clinical use only ☐ Workplace accommodations ☐ Legal/compensation matters ☐ Other: