

Attention Deficit Disorders Diagnosis Documentation Checklist for Treating Physician

This form is to be used in cases where an evaluation report is not available. Please complete this form and return to the student. Please note that family members are not considered appropriate evaluators. It is most important that you thoroughly explain any ADD/ADHD symptoms and indicate their impact on functioning. **If you wish to provide additional information, please attach it to the back of these forms.** The information you provide will *not* become part of the student's educational records. **Thank you.**

Patient's name: _____ Patient's date of birth: _____

Date of most recent (please circle one) [evaluation/meeting with patient]: _____

I. If patient was diagnosed previously, please respond to the following:

Patient previously diagnosed with (please circle one) [ADD / ADHD] in _____ (year)
when s/he was _____ (age) by _____
(please print the name of physician)

Prior treatment (check all that apply):
 pharmacotherapy
 psychotherapy
 other (please specify): _____

II. In order to (please circle one) [confirm prior diagnosis /diagnose] the presence of ADD/ADHD, I have:

- A. Conducted a semi structured diagnostic interview/consultation with the patient and gathered background information regarding ADD symptoms in the patient's:
1. developmental history
 2. academic history (elementary, high school, college)
 3. psychosocial history
 4. familial history (medical and psychiatric).
- B. Conducted an assessment using the DSM-IV for ADD/ADHD
- C. Administered and evaluated responses from ADD/ADHD rating scale(s)
- D. Conducted assessments to rule out any medical conditions, mood, behavioral, neurological and personality disorders as the cause of the attentional and/or executive deficits.

E. Confirmed that ADD/ADHD symptoms have been present since childhood.

F. Confirmed impairment from symptoms of ADD/ADHD is present in (check all that apply):

academic situations

work situations

social situations

III. Diagnosis

Based on the above information, the student meets the most current DSM criteria for:

314.00

Predominantly Inattentive

Predominantly Hyperactive Impulsive

314.01 Combined

314.9 Not otherwise specified

OR

I do not believe that this student has an attention deficit disorder.

IV. Comorbidity (please check all that apply):

I have diagnosed the patient with the following comorbid condition(s):

Depression

Bi-polar

OCD

Anxiety Disorder

Other: _____

Patient previously diagnosed with a learning disability (please attach the LD testing documentation.). Student has the following LD: _____

I suspect the presence of a learning disability and have suggested the patient pursue neurological/cognitive testing (if testing has been completed, please attach report)

I do not suspect the presence of a learning disability

V. ADD treatment and recommendations (please check only one option below)

Patient **is** receiving pharmacotherapy and his/her symptoms are no longer having a major impact on the patient's life

OR

Patient **is** receiving pharmacotherapy and is experiencing a major impact on his/her life from the following symptoms :

OR

Patient **is not** receiving pharmacotherapy and is experiencing a major impact on his/her life from the following symptoms:

(Please Print/Type the Name of Physician Completing this Form)

Signature of Physician Completing this Form

Date

Attention Deficit Disorders: Update of Treatment Checklist for Treating Physician

This form is to be used to update an evaluation that is more than six months old if. Please complete this form and return to the student. Please note that family members are not considered appropriate evaluators. It is most important that you thoroughly explain any ADD symptoms and indicate their impact on functioning. If you wish to provide additional information, please attach to the back of these forms. The information you provide will *not* become part of the student's educational records. Thank you.

Patient's name: _____ Patient's date of birth: _____

Date of the most recent evaluation meeting with patient: _____

I. Patient diagnosed by (please circle one) [me/ previous doctor] with:

ADD

ADHD

II. Updated ADD Treatment and recommendations:

Patient **is** receiving pharmacotherapy and **does not require any accommodations.**

OR

Patient **is** receiving pharmacotherapy and at the present time requires accommodations to mitigate the impairment(s) caused by the following symptoms :

OR

The patient is not receiving pharmacotherapy and requires accommodations to mitigate the impairment(s) caused by the following symptoms:

(Please Print/Type the Name of Physician Completing this Form)