

ADHD Assessment Checklist

ADHD assessment is not a “quick diagnosis and a script” job. It’s a structured, evidence-based process that usually takes ~2-3 hours of focused assessment to do it properly – & there are real risks if you cut corners. (AADPA, 2022; Asherson et al., 2024; NICE, 2018).

1. IDENTIFYING DETAILS & CONTEXT FOR ASSESSMENT

Name: _____ DOB: ___ / ___ / ___
MRN: _____ Date: ___ / ___ / ___
Assessor: _____

“What’s the main thing you want help with?”
Patient’s own one-sentence summary:

1A. Referral pathway & “why now?”

Referral source (who sent them / suggested this):

- Self Parent Partner GP Psychiatrist Psychologist
 School / Uni Workplace / OH&S Other: _____

Who is most concerned?

- Patient Parent Partner/Family School/Uni Work

Why now (triggers for assessment)?

- ↑ School / uni demands (exams, transition, higher workload)
 Work role changed (promotion, performance issues, burnout)
 Relationship stress / separation
 Child, family member, friend recently diagnosed ADHD / ASD
 Mental health deterioration (mood, anxiety, burnout)
 Substance use concerns
 Concerns about previous “misdiagnosis”
 Requested assessment for documentation / accommodations / driving / Centrelink
 Other key trigger: _____

1B. Main presenting themes (tick all that apply)

- Inattention / distractibility / “scattered”
 Disorganisation / poor planning / procrastination
 Hyperactivity / restlessness (body or mind)
 Impulsivity (speech, decisions, spending, driving, sex, substances)
 Emotional storms/rejection sensitivity
 Chronic overwhelm / burnout / shutdowns
 School / uni difficulties (workload, assignments, exams)
 Work difficulties (performance, deadlines, errors, feedback)
 Relationship difficulties (conflict, intimacy, parenting strain)
 Social difficulties (friends, masking, misreading cues)
 Sleep problems / circadian chaos
 Sensory issues (noise, crowds, textures, food, clothing)
 Risk behaviours (driving, self-harm, substances, unsafe sex)

1C. What are they hoping for? (goals for assessment)

- To understand whether ADHD (and/or ASD, learning issues) is present
 To make sense of lifelong patterns / “why I am like this”
 To discuss medication options
 To get help with organisation / study / work strategies
 To improve relationships / parenting
 To access school / uni / workplace supports (documentation, reports)
 To clarify diagnosis where there are mixed opinions already
 Other key goal(s): _____

1D. Previous diagnoses & current psychotropic treatment

Previous diagnoses:

- ADHD Autism / ASD Learning disorder(s)
 Depression Anxiety disorder(s)
 Bipolar spectrum Psychosis / schizophrenia
 PTSD / complex trauma Personality disorder
 Substance use disorder
 Other: _____
 No formal mental health / NDD diagnosis recorded

Current psychotropic medications:

- None
 Stimulant(s): _____
 Non-stimulant ADHD medication: _____
 Antidepressant(s): _____
 Mood stabiliser / antipsychotic: _____
 Other relevant meds (e.g. sleep, anxiety, SUD, cardiac): _____

2. DSM-5-TR ADHD SYMPTOMS – CHILDHOOD & ADULT

Instructions: Tick symptoms that occurred frequently and caused functional impairment, were inconsistent with developmental level, or differed significantly from same-age peers.

CHILD column:

• Under 18: ✓ symptoms currently present & impairing (home/school/peers).

• Over 18: ✓ symptoms clearly present & impairing < age 12.

ADULT column:

• Under 18: Leave blank

• Over 18: ✓ symptoms clearly present & impairing in last 6–12 months

INATTENTION (≥6 traits (≥5 if 17+) for ≥6 months, inconsistent with developmental level, impacts functioning)

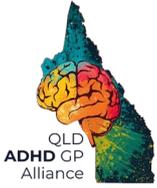
#	Symptom (DSM-5-TR) Often...	CHILD <12yo	ADULT last 6/12	Example (Child / Adult)
1	Poor attention to detail or makes careless mistakes	<input type="checkbox"/>	<input type="checkbox"/>	Child: Leaves obvious questions blank or misreads instructions on tests. Adult: Makes avoidable errors after getting the hard bit done, gets less-critical detail wrong. Misreads things. Skims, gets the gist, misses the fine detail.
2	Difficulty sustaining attention	<input type="checkbox"/>	<input type="checkbox"/>	Child: Drifts off in lessons/conversations, needs repeated redirection to task. Adult: Zones out in long meetings; rereads same paragraph; dislikes reading instruction manuals/reports/research papers. Loses track in multi-step tasks.
3	Does not seem to listen	<input type="checkbox"/>	<input type="checkbox"/>	Child: Teacher/parent feels they “ignore” instructions unless name is repeated. Adult: Partner complains they “never listen” and forgets what was just discussed.
4	Fails to follow through or finish tasks	<input type="checkbox"/>	<input type="checkbox"/>	Child: Starts homework/chores but leaves it half-done unless supervised closely. Adult: Flakey. Chores half/non-essential work/personal tasks/projects half done. Tendency to move on once it gets dull. Great at challenges, then loses interest.
5	Disorganised	<input type="checkbox"/>	<input type="checkbox"/>	Child: School bag, desk, room are messy; loses track of homework tasks. Adult: Struggles with planning, prioritising what’s important and juggling multiple work tasks. Jumping from one mission critical task to another, hard to plan ahead.
6	Avoids or dislikes tasks needing sustained effort	<input type="checkbox"/>	<input type="checkbox"/>	Child: Procrastinates homework, reading, chores, study until the last minute. Adult: Procrastinates on “boring admin” & “too hard” tasks until the last minute. Tendency to chase “cheap & easy wins”, hard delaying gratification.
7	Loses necessary items	<input type="checkbox"/>	<input type="checkbox"/>	Child: Often misplaces books, pencils, notes, sports gear at home/school Adult: Often loses keys, phone, wallets, pens, ID cards, important documents.
8	Easily distracted	<input type="checkbox"/>	<input type="checkbox"/>	Child: Looks out the window or shifts attention to every noise in the classroom. Adult: Jumps between tasks/tabs; distracted by notifications/random thoughts. Easily side-tracked and lots of “side quests” instead of sticking to the one thing.
9	Forgetful in daily activities	<input type="checkbox"/>	<input type="checkbox"/>	Child: Forgets to bring homework, permission slips or lunch; misses messages. Adult: Flakey, forgets appointments, returning calls, bills/fines, laundry left in washer/on line, what they needed at the shop. Forgot where I was going with this.

Inattention symptom count: Childhood: ___ / 9 Adult/Current: ___ / 9

HYPERACTIVITY / IMPULSIVITY (≥6 traits (≥5 if 17+) for ≥6 months, inconsistent with developmental level, impacts functioning)

#	Symptom (DSM-5-TR) Often...	CHILD <12yo	ADULT last 6/12	Example (Child / Adult)
1	Fidgets or squirms	<input type="checkbox"/>	<input type="checkbox"/>	Child: Constantly fidgets, taps, plays with objects at the desk. Adult: Jigs legs, taps pen, plays with objects/hair/etc during consults/meetings.
2	Leaves seat when expected not to	<input type="checkbox"/>	<input type="checkbox"/>	Child: Gets up & walks around the classroom when bored, without permission. Adult: Frequently makes any excuse to get up/walk around/move, avoids jobs/studies where prolonged sitting is a requirement.
3	Runs/climbs inappropriately; or restless in adults	<input type="checkbox"/>	<input type="checkbox"/>	Child: Excessively active “exhausting”, “full on”, “into everything”, “can’t stop”. Adult: Inner restlessness; strong desire to keep busy, active, “doing something”.
4	Difficulty playing or enjoying downtime quietly	<input type="checkbox"/>	<input type="checkbox"/>	Child: Talks loudly, struggles with quiet reading or calm games. “too boring” Adult: Finds it hard to relax & not be always doing something; always wants to be productive, exercising, gaming or something else stimulating or fun.
5	“On the go” or “Driven by a motor”	<input type="checkbox"/>	<input type="checkbox"/>	Child: “always on the go” and hard to tire out. Relentless. Adult: They never slow down & are constantly doing things, “hard to keep up with”
6	Talks too much	<input type="checkbox"/>	<input type="checkbox"/>	Child: Talks over others in class, excessive chatter home/school/everywhere. Adult: Keeps talking when others have moved on, waffly, rambly, long-winded.
7	Blurts out answers Interrupts	<input type="checkbox"/>	<input type="checkbox"/>	Child: Calls out in class before being called on; interrupts teacher’s questions. Adult: Finishes people’s sentences or blurts out answers, overshares.
8	Difficulty waiting turn	<input type="checkbox"/>	<input type="checkbox"/>	Child: Struggles to wait in queues or for their turn in games. Adult: Impatient in traffic, queues or discussions; visibly frustrated waiting.
9	Interrupts/Intrudes	<input type="checkbox"/>	<input type="checkbox"/>	Child: Butts into others’ games uninvited, interrupts conversations. Adult: Butts into conversations, emails, tasks; oversteps social/work boundaries.

Hyperactivity/Impulsivity symptom count: Childhood: ___ / 9 Adult/Current: ___ / 9



CURRENT FUNCTION & IMPAIRMENT (≥2 DOMAINS)

- Work / study (performance, deadlines, errors, job changes, failures).
- Home / parenting / life admin (bills, appointments, routines, clutter).
- Relationships (peers, partners, family, colleagues, conflict, emotional reactivity, forgetfulness, rejection sensitivity).
- Driving / safety / accidents (traffic accidents, speeding fines, licence issues, clumsiness).
- Finances (impulsive spending, debt, missed payments).
- Self-care (sleep, hygiene, eating, exercise).

Impairment summary:

- Clear evidence of **functional impairment** in **≥2 domains** (as above) documented.
- Several traits present before age 12
- Not better explained by another mental disorder (e.g. mood disorder, anxiety, psychosis)

Overall pattern (current):

- Combined Predominantly inattentive Predominantly hyperactive/impulsive

Subthreshold but clinical significant ADHD traits. Details: _____

3. CHILDHOOD ADHD ONSET & SCHOOL IMPACT

Approximate age when difficulties first obvious: _____ years.

Clear evidence of **lifelong pattern**, not just a recent change.

Early patterns (tick any that fit):

- "Always on the go" / very busy child
- Very talkative / interrupts / "too much" for adults/peers
- "In their own world" / dreamy / off with the fairies
- Chronically disorganised (bag/room/desk, loses stuff)
- Other: _____

Work habits & executive function

Task initiation / completion

- Chronic procrastination on homework/assignments
- Frequently needed **adult supervision** just to start or finish tasks
- Many tasks left **half-done** or rushed right at the deadline

Organisation & time

- Regularly forgot homework, notices, lunch, equipment, sports gear
- Could not keep bag/locker/desk/school items in order
- Poor use of diary/planner; relied on memory or parents/teachers

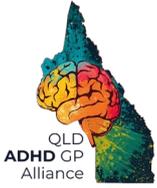
Academic performance pattern

Overall pattern:

- Consistently below expected
- Patchy / up-and-down
- Consistently good / high-achieving (but high cost)
- Needed **more time/effort++ than peers** to get similar results
- Homework/assignments/study often left to the **last minute**
- Could answer questions in class but **lost marks on long tasks / projects / exam organisation**
- Teachers description: "**not meeting their potential**" or "**would do better if they studied/worked harder/talked less**"
- Marks were good, but **organisation, planning or follow-through** were consistently poor

Attention profile

- Could focus **very well on interests** but struggled with "boring" or repetitive work
- Zoned out in class/lectures but could "cram" or rely on natural ability
- Needed frequent movement/breaks or fidgeting to stay engaged



4. NEURODEVELOPMENTAL HISTORY

Peri-natal

- No significant peri-natal issues
- Peri-natal issues (e.g. prematurity, NICU/SCN, substance exposure, major complications)

Details: _____

Early Development

Motor milestones

- No concerns
- Gross motor delay / clumsiness (late walking, poor coordination, DCD suspected)
- Fine motor delay (handwriting, buttons, cutlery)

Speech / language

- No concerns
- Late talking / language delay
- Required speech therapy

Early social / play

- No concerns
- Limited eye contact / pointing / shared play
- Preference for adults / solitary play
- Marked rigidity / need for sameness

Details (any neurodevelopmental delay red flags): _____

Previous Neurodevelopmental Diagnoses / Assessments

- ADHD
- Autism / ASD
- Intellectual disability
- Specific learning disorder(s)
- Developmental coordination disorder (DCD/dyspraxia)
- Tic disorder / Tourette's
- Other neurodevelopmental condition: _____
- No previous neurodevelopmental diagnosis documented

Details: _____

6. COMORBID SYMPTOMS – MOOD, ANXIETY, TRAUMA

6A. Depression

Status:

- None / minimal
- Past only
- Current significant

Features (tick):

- Persistent low mood / emptiness
- Loss of interest / pleasure
- Guilt / worthlessness / self-criticism
- Fatigue / low energy / slowed up
- Thoughts of self-harm / suicide

Social

- No significant social concerns
- Difficulty making/keeping friends
- Bullied / socially isolated
- Very intense or one-sided interests / conversations

Sensory

- Marked sensory sensitivity
- No notable sensory issues

Emotion / behaviour

- No major behaviour concerns
- Marked emotional storms / meltdowns / shutdowns
- Persistent oppositional / defiant / conduct-type behaviours

Learning & School Profile

- No learning concerns reported
- Suspected / diagnosed learning disorder (reading / writing / maths)
- Repeated a year / significant academic support needed
- "Bright but disorganised / underperforming relative to ability"
- High-achieving but at significant cost (late nights, parent scaffolding, distress)
- Expelled from school or multiple suspensions
- Did not finish school

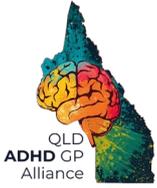
6B. Anxiety disorders (GAD, panic, social, OCD, etc.)

Status:

- None / minimal
- Past only
- Current significant

Prominent features:

- Generalised worry / "on edge"
- Panic attacks
- Social anxiety / fear of scrutiny
- Obsessions / compulsions
- Phobias (eg driving, flying, medical)



6C. Trauma / PTSD / Complex Trauma

History:

- No identified trauma
- Single-event trauma
- Repeated / developmental / complex trauma

Current impact (tick):

- Re-experiencing (flashbacks, nightmares, intrusive memories)
- Avoidance (places, people, reminders)
- Hypervigilance / startle / “on guard”
- Emotional numbing / dissociation
- Unstable relationships / self-worth tied to trauma

7A. Bipolar spectrum / hypomania / mania

Only tick bipolar red flags if there have been **distinct episodes** (days–weeks) where **several of these symptoms happened together at the same time**, representing a **clear change from the person’s usual self** (not just their baseline ADHD, temperament, or personality).

Red flags – episodic clusters (tick any):

- Distinct periods of **reduced need for sleep** without feeling tired **during the same time as** other mood/energy changes
- Grossly deranged sleep** pattern (e.g. awake most of the night for days, day–night reversal) **with concurrent mood/behaviour change**
- Clearly **elevated or irritable mood** for days to weeks, **plus other symptoms below in the same episode**
- Mixed features** – periods with **both** elevated/irritable mood **and** prominent depressive symptoms and/or marked agitation **at the same time**
- Grandiosity** or markedly increased confidence / sense of special abilities **within that same episode**
- Marked **risk-taking** (spending, sex, substances, driving, big life decisions) **during the same mood / energy change**
- Very **fast speech / racing thoughts** beyond baseline ADHD “busy brain”, **co-occurring with** the above changes
- Clear **on/off episodes** where others describe them as “not themselves” for several days–weeks, then back to baseline
- Affective switch** into hypomania/mania after starting or increasing an **SSRI**, with **clustered** mood/energy/behaviour changes
- Affective switch** into hypomania/mania after starting or increasing a **stimulant**, with **clustered** mood/energy/behaviour changes

Risk factors / history (tick):

- Previous diagnosis of bipolar / hypomania / mania
- First-degree family history** of bipolar or clear episodic mood disorder

Overall impression:

- No clear bipolar history
- Possible bipolar spectrum – needs further workup
- Likely / previously diagnosed bipolar
- Likely elevated risk of bipolar spectrum (subthreshold episodes / switches / strong FDR history)

Details: _____

7B. Psychotic symptoms

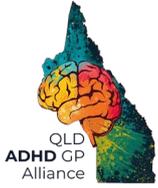
Red flags (tick):

- Hallucinations (auditory, visual, other)
- Fixed **delusional beliefs** (persecutory, grandiose, referential, bizarre, etc.)
- Thought disorder / **disorganised thinking** or speech
- Negative symptoms** (apathy, social withdrawal, blunted affect, reduced speech)
- Previous drug-induced psychosis** (e.g. stimulants, cannabis, hallucinogens, GHB)
- First-degree family history** of schizophrenia / psychotic disorder

Overall impression:

- None
- Possible previous psychosis – needs further assessment
- Established psychotic disorder
- Likely elevated risk of psychotic disorder** (attenuated symptoms / heavy cannabis / strong FDR history)

Details: _____



8. SUBSTANCE USE

Any substance use disorder / treatment history:

Yes No

8A. Alcohol

Pattern:

- Minimal / none
- Regular but low-risk
- Binge pattern
- Likely alcohol use disorder

Red flags (tick):

- Loss of control / daily use
- Withdrawal / morning use
- Impact on work / relationships / health

8B. Cannabis

Pattern:

- None / experimental
- Occasional
- Regular (weekly)
- Heavy / daily

Red flags:

- Cognitive dulling / amotivation
- Dependence / difficulty cutting down
- Cannabis used to self-medicate ADHD / anxiety / sleep

8C. Other substances

Tick any:

- Stimulants (prescribed / non-prescribed)
- Benzodiazepines
- Opioids
- GHB / party drugs
- Other: _____

8D. Tobacco / vaping / nicotine

None Occasional Daily / dependent

8E. Substance-related harms

Tick any:

- Overdose / withdrawal emergencies
- Legal problems
- Financial harm
- Relationship breakdown
- Physical health complications

Notes: _____

9. FAMILY & MEDICAL HISTORY

9A. Family psychiatric / neurodevelopmental history (first-degree or strong pattern)

Tick all that apply:

- ADHD Autism / ASD Learning disorders
- Depression Anxiety disorders
- Bipolar spectrum Psychosis / schizophrenia
- Substance use disorder
- Suicide / suicide attempts
- Other: _____

If highly relevant (who / what): _____

Metabolic / endocrine:

- Hypertension
- Diabetes / pre-diabetes
- Obesity
- Sleep apnoea
- Thyroid disease

Neurological:

- Head injury / TBI
- Seizures / epilepsy
- Tics / Tourette's
- Known genetic / developmental syndrome

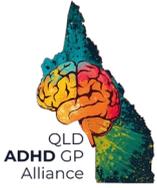
Other relevant conditions: _____

9B. Medical history – key ADHD-relevant items

Cardiovascular:

- None known
- Structural heart disease
- Arrhythmia / syncope
- Family history of sudden cardiac death <40

Allergies / medication adverse reactions: _____



10. COLLATERAL INFORMATION & RATING SCALES

10A. Collateral obtained from:

- Parent / caregiver
- Partner / spouse
- Employer / colleague
- School / uni reports
- Previous specialist letters / psychologist reports
- Other: _____

Overall collateral impression:

- Strongly supports ADHD pattern
- Mixed picture
- Does **not** support ADHD

Details: _____

10B. Rating scales completed

Children:

- SNAP Vanderbilt
- Young DIVA-5 CADDRA Teacher Assessment Scale
- Other: _____

Adults:

- ASRS WURS
- DIVA-5
- Other: _____

Impression:

- Scales consistent with ADHD
- Borderline / mixed
- Scales not strongly supportive

Details: _____

11. EXAMINATION & INVESTIGATIONS

11A. Mental State Examination

Appearance / behaviour

- Within normal limits for context
- Poor self-care / dishevelled
- Agitated / restless
- Slowed / reduced activity
- Guarded / suspicious / odd

Speech / psychomotor

- Normal
- Fast / pressured / difficult to interrupt
- Slow / reduced
- Increased psychomotor activity (restless, fidgety)
- Decreased psychomotor activity (slowed, low energy)

Mood / affect

Subjective mood: Euthymic Low Anxious Irritable

Other: _____

Affect: Normal range Restricted Labile Incongruent

Thought form

- Coherent / goal-directed
- Circumstantial
- Tangential
- Flight of ideas
- Other formal thought disorder: _____

Thought content & risk

Suicidality:

- Denies suicidal ideation

- Passive "better off dead" thoughts only
- Active suicidal ideation without plan/intent
- Active suicidal ideation with plan/intent or past attempt(s)

Psychotic content (see 7B):

- No psychotic content evident
- Possible overvalued ideas / attenuated psychotic symptoms
- Clear delusional content

Perception

- No hallucinations / perceptual disturbance reported
- Possible perceptual disturbance
- Clear hallucinations (auditory / visual / other)

Cognition

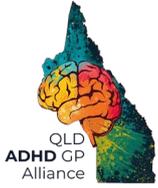
- Alert and oriented
- Attention/working memory grossly adequate for interview
- Marked distractibility observed in session
- Possible broader cognitive impairment (consider further assessment)

Insight / judgement

- Good
- Partial
- Poor

If any mental state findings are important/abnormal,

Details: _____



11B. Physical examination

Vitals:

BP _____ / _____ HR _____ Wt _____ kg Ht _____ cm
BMI _____

- Percentiles calculated (if <18 & still growing)
- Basic systems screen (neuro, thyroid, sleep etc as indicated)
- Cardiovascular exam

11C. Investigations (only if indicated – not routine for all)

Blood tests (if indicated):

- Not indicated today
 - Indicated and ordered (guided by clinical context):
All: FBC, U&E, LFTs, lipids, HbA1c, TFTs, others)
Adults: B12/folate, lipids
 - Targeted investigations ordered (ie coeliac serology, vit D)
-
- Previously done & reviewed – no major concerns
 - Previously done – clinically significant issues: _____

12A. ADHD diagnostic impression (today)

Tick one that best fits **today's** assessment:

- ADHD **highly likely**: clear, consistent ADHD pattern across history, collateral and rating scales
- ADHD **probable**: core ADHD pattern is likely, but / difficult to separate from comorbidity / possible alternative explanations
- ADHD **possible but not established**: some features present, but significant gaps / uncertainty
- ADHD **unlikely**: difficulties better explained by other condition(s)

Main reasons ADHD remains uncertain or complicated:

- Severe **depression** could be driving inattention / poor motivation
- Severe **anxiety** could be driving avoidance / poor concentration
- Possible **bipolar spectrum** (episodic mood/energy change, affective switches, similar symptom pattern to ADHD)
- Possible / prodromal **psychotic disorder**
- Active **substance use disorder** / heavy cannabis / non-prescribed stimulant use (treat / stabilise first)
- Significant **medical / neurological comorbidity** (e.g. OSA, TBI, epilepsy, thyroid, etc.) not yet clarified (further workup)

Hearing & Vision tests (in children)

- Not indicated today
- Indicated and ordered

ECG (if indicated – not routine):

- Not indicated today
- Indicated & ordered (e.g. syncope, palpitations, structural heart disease, non-innocent murmur, concerning vitals)
- Previously done or completed today & reviewed – acceptable for stimulant trial
- Previously done or completed today – abnormal / requires further cardiac review prior to stimulant trial

Urine drug screen (UDS) – if indicated:

- Not indicated today
- Indicated and ordered (e.g. suspected SUD, diversion risk, medico-legal/licensing requirements)
- Results reviewed and consistent with history
- Results discordant with history (brief note): _____

-
- Insufficient information** – limited collateral, limited school reports, incomplete rating scales
 - Other reason(s) for uncertainty: _____

12B. Diagnostic confidence / What needs to happen next?

Additional assessment is needed

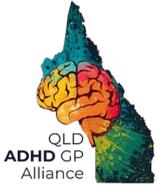
- Diagnostic second opinion** indicated, refer to ADHD-expert:
 - Psychiatrist
 - Paediatrician
 - Psychologist
 - ADHD-expert GP

Provisional ADHD diagnosis made:

ADHD is *probable/highly likely* on current evidence

If provisional diagnosis:

- I am reasonably confident in my clinical training and judgement
- I have spent adequate time assessing this patient
- I have obtained **multi-informant supportive evidence** where feasible (collateral, reports, rating scales)
- I know the **appropriate escalation pathways** if concerns arise



13A. Management & medication decision (today)

Today's ADHD medication decision:

- Suitable for **stimulant trial** (if appropriate/state laws permit)
- Suitable for **non-stimulant trial** (e.g. atomoxetine / guanfacine XR / clonidine / other)
- Other medication** trial to stabilise a comorbid condition.
Details: _____
- For **non-pharmacological strategies +/- psychoeducation**
- Defer treatment today – further assessment to continue

13B. If prescribing – safety & governance self-check

- I have **considered the risk** of bipolar or psychotic spectrum disorders, substance use disorder, other conditions that may be aggravated by ADHD medications, and misuse or diversion.
- I have **screened for red flags** (episodic mood change, grossly deranged sleep, affective switches, past drug-induced psychosis, strong FDR bipolar/psychosis).
- I have used **shared decision-making** to discuss (expected benefits, common side effects, rare but serious risks, early warning signs that should trigger review or escalation)
- I have considered and documented **escalation pathways** should issues arise:
 - Crisis options (e.g. acute MH triage, ED, 000)
 - Non-urgent review options
- For **stimulant trial** (if applicable today): I have considered:
 - Cardiac risk factors and vitals
 - Risk of aggravating any comorbid conditions
 - Substance use/diversion risk
 - Appropriate choice of agent, starting dose and titration plan
- For **any other medication** (if chosen): I have also considered:
 - Interaction with current medications and comorbidities
 - When to revisit the stimulant question (if appropriate later)

13C. Referrals

- Referral to ADHD expert (include summary of workup already done). Whom: _____
- Referral to psychologist
- Referral to ADHD coach
- Referral for parent training
- Referral for further neurodevelopmental assessment
- Referral not required today

13D. Psychoeducation, safety-netting & communication

- Patient received **verbal psychoeducation** about ADHD and/or comorbidities
- Patient given **written resources**,
 - e.g.: Australian ADHD consumer guide

Clear safety-netting given:

- When to return early for review (e.g. side effects, sleep, mood, risk, function)
- What symptoms/signs should trigger urgent help
- Whom to contact in case of crisis (GP, after-hours service, mental health triage, ED, 000)

Letter / report prepared (or planned) for:

- School University Workplace / OH&S
- Including recommended reasonable accommodations, if indicated

13D. Monitoring & follow-up

Follow-up planned in:

- 1-2 weeks
- 3-4 weeks
- 2-3 months
- 6 months

Monitor:

- ADHD symptoms & function
- Mood / anxiety / risk
- Substance use
- Side effects / vitals / weight / growth
- Sleep
- Diversion risk
- School / work performance
- Family / relationship impact

- Arrange collateral for next follow up

Clinician signature: _____ Date: ____ / ____ / ____

Disclaimer:

This checklist is intended for use by appropriately trained medical professionals.

It is a supplementary resource and does **not** replace local legislation, clinical guidelines, PBS/TGA recommendations, specialist advice, or structured mentoring.

Always practice within your professional scope; clinical knowledge and abilities; adhere to state or territory regulations; and escalate care whenever patient safety is uncertain.