

ADHD MEDICATION STRUCTURED REVIEW CHECKLIST

Use this form for initial shared-care appointments, titration & troubleshooting reviews, & at least yearly medication & safety reviews

Reason for review (tick all that apply)

- Initial shared care appointment:** *ADHD diagnosis and medications started elsewhere*
- Restarting ADHD medication...** *... after a significant break*
- Planned 6-12 monthly ADHD medication check-in & safety review**
- Fine-tuning:** *Minor dose adjustment / tweak / optimising regimen*
- Troubleshooting:** *Medications not working well and/or bothersome side effects; but no red flag side effects*
- Deterioration / possible red flags:** *Concerning worsening function, risk, moods, sleep, substance use, or medication safety issues*
- Routine repeat script:** *Everything stable, no new concerns likely → **could use Routine Low-risk Script Renewal checklist***
- Other issues today: _____

1. Diagnosis

Diagnosed & commenced on ADHD medication by:

Details: _____

- Psychiatrist Paediatrician GP
- Psychologist report – Details: _____

Date / approx year of diagnosis: _____

Diagnosis:

- Provisional – yet to respond to medication
- Provisional – partially responsive to medication
- Confirmed – responding ‘as advertised’ to medication and significantly improving

- Major psychiatric comorbidity noted (mood, anxiety, psychosis, PTSD, personality): _____
- Neurodevelopmental comorbidity noted (e.g., autism, ID, LD, tic, FASD): _____

Diagnosis still consistent with history?

- Yes – childhood onset + ongoing impairment
- Partially – clarify at next longer review
- Uncertain – will seek further information / specialist review

Shared-care / continuation arrangement:

- S8 permit / approval details checked & recorded (if required)
- Written report / plan on file (dated: _____)
- Permit / approval no.: _____ Valid to: _____
- S8 permit / approval / authority to be applied for today
- Not applicable / not required

Current role:

- Initiating prescriber
- Prescribing in shared-care / collaborative-care arrangement
- Sole ongoing prescriber

2. Current regimen & adherence

Current ADHD or other Mental Health medication(s):

Name/formulation: _____

Dose & timing: _____

Adherence:

- As prescribed most days
- Occasionally missed doses
- Frequently missed / inconsistent
- Taking less than prescribed
- Meds often run out too early between doses
- Meds often run out too early in the day

Is the patient adjusting the dose themselves, or any non-prescribed dose escalation or use?

- No
- Yes – details: _____

Name/formulation: _____

Dose & timing: _____

Name/formulation: _____

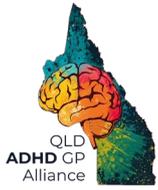
Dose & timing: _____

Adherence supports in place:

- Written plan / dosing instructions supplied
- Blister pack / dose administration aid
- Phone alarm / app reminders set up
- Parent / partner supervising meds (if appropriate)
- Pharmacy scheduled pick-up of meds (if indicated)

If yes, do you have any concerns about that?

- No, it's innocent / a miscommunication and not alarming
- Yes – details: _____



3. Function & benefit

Treatment effectiveness since starting current regimen:

- Obvious / Marked benefit
- Some benefit
- Minimal / Uncertain benefit
- No benefit / worse

Functional Areas targeted by treatment:

- Work / study
- Organisation / time management
- Driving / Safety
- Home / Personal / Finances
- Parenting
- Relationships
- Self-medicating
- Other: _____

Brief functional summary:

On medication, pt reports: _____

Without medication / when it wears off: _____

Outcome Measure used to evaluate progress:

Adults:

- ASRS:** Baseline (date/score): _____ Current: _____
- SNAP:** Baseline (date/score): _____ Current: _____
- WFIRS-S:** Baseline (date/score): _____ Current: _____
- WFIRS-Partner:** Baseline (date/score): _____ Current: _____
- ACOS-S:** Baseline (date/score): _____ Current: _____
- Other:** Baseline (date/score): _____ Current: _____

Children:

- Vanderbilt:** Baseline (date/score): _____ Current: _____
- SNAP:** Baseline (date/score): _____ Current: _____
- WFIRS-Parent:** Baseline (date/score): _____ Current: _____
- Iowa Conners:** Baseline (date/score): _____ Current: _____
- SWAN:** Baseline (date/score): _____ Current: _____
- Other:** Baseline (date/score): _____ Current: _____

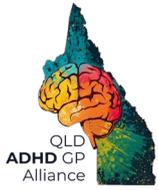
4. Adverse effects & tolerability

- Insomnia / delayed sleep: _____
- Raciness instead of calm: _____
- "Irritability": _____
- "crash": _____
- Appetite ↓ / weight loss: _____
- Anxiety / panic: _____
- Low mood / dysphoria: _____
- Palpitations: _____
- Tics / repetitive movements: _____
- Jaw clenching / Bruxism: _____
- Headache: _____
- GI upset: _____
- Sexual dysfunction: _____

- Emotional blunting / 'lost sparkle' / 'zombie' feeling: _____
- Late-day rebound irritability / crash / mood drop: _____
- Other: _____

Overall tolerability:

- No side effects
- Tolerable side effects (benefit>>side effect)
 - Mild, acceptable
 - Moderate – monitoring / adjust
 - Poor – change needed
- Intolerable side effects / Failed trial (side effect > benefit)



5. Sleep screen

Total sleep duration:

- Normal / Unconcerning**
- Mildly short → Monitor**
Adults ≤ 7hrs, Teens ≤ 8hrs, Children ≤ 9hrs
→ *Brief sleep hygiene + stimulant timing review + monitor next visit*
- Concerning → Intervene if able**
Adults ≤ 6hrs, Teens ≤ 7hrs, Children ≤ 8hrs
→ *Optimise routines, assess comorbid mood d/o, consider melatonin/clonidine, monitor closely*
- High-risk sleep → Revisit comorbidity ± Refer / Escalate:**
Adults ≤ 5hrs, Teens ≤ 6hrs, Children ≤ 7hrs
→ *Avoid stimulant dose escalation until sleep stabilised; Prioritise sleep/mental health interventions*
→ *Consider dose reduction or temporary pause; Escalate if high-risk features present*

Night waking pattern:

- Monitor:**
≤ 2 brief wakings/night, back to sleep in < **20–30 min**, feels mostly refreshed.
→ *Simple hygiene + review; OK to adjust stimulants if otherwise stable*
- Assess & Intervene:**
> 2 wakings/night or any waking > 30 min or total awake time > 45min/night
→ *Optimise sleep first; consider behavioural strategies, melatonin, screen for OSA/RLS.*
- Refer / escalate care:**
Waking **multiple times** with gasping / snoring / choking
Severe insomnia linked to **mood instability, suicidality, psychosis**, or near-miss accidents
→ *Avoid stimulant dose escalation until sleep stabilised; Prioritise sleep/mental health interventions*
→ *Consider dose reduction or temporary pause; Escalate if high-risk features present*

6. Psychiatric screen

Psychosis – Previous Dx No Yes
Current symptoms / paranoia No Yes

Details: _____

Bipolar – Previous Dx No Yes
Current hypo(mania)/mixed Sx No Yes

Details: _____

Any other severe mood disorder No Yes
e.g., melancholic depression, OCD, complex PTSD
Current symptoms No Yes

Details: _____

Newly apparent or more obvious other symptoms since starting medication:

e.g., autism traits, anxiety, OCD, trauma No Yes

Details: _____

Self-harm / suicide attempts? No Yes

Details: _____

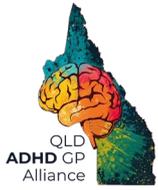
Since last review / dose change:

- No new psychotic symptoms
- No new manic/hypomanic symptoms
- No significant mood deterioration or active suicidal ideation
- New significant or mood concerns:

Details: _____

If new psychosis or clear high-risk mania emerges:

Cease stimulant/atomoxetine/bupropion/SNRI if safe to do so, arrange urgent mental health review, treat mood/psychotic disorder first; Consider referral / escalation to ADHD-expert colleague for further review, management & medication decisions



7. Self-Medication / Substance use & Real Time Prescription Monitoring (i.e. Qscript) check

Overall:

- No concerns
- Concerns: _____

Alcohol:

- No concerns
- Concerns – details: _____

Nicotine / vaping::

- Details: _____

Cannabis: _____

- Prescribed: Yes No
- High potency strains: Yes No
- Daily or near-daily use: Yes No
- Early onset of use (<16 yrs): Yes No

- Concerns – details: _____

Illicit drugs / non-prescribed meds:

- Previous Drug-induced psychosis Yes No
- Current use Yes No

- Details: _____

Real time prescription monitoring checked today?

- Yes – no concerning entries
- Yes – concerns: _____
- Not checked – reason: _____

Signs of misuse / diversion:

- Multiple prescribers / pharmacies
- Intoxication at review
- Early script requests - How often: _____
- Lost scripts – How often: _____
- Other: _____

If SUD / diversion risk present, formulation strategy:

- Long-acting stimulant
- Non-stimulants
- Supervised dosing / staged supply / limited quantities
- Single prescriber
- Single pharmacy
- No early replacements except documented theft/EMR note.

- Rationale: _____

8. Physical exam, Growth, Investigation

For Adults:

Vitals today: BP: ____ / ____ HR: ____ bpm

Weight: ____ kg Prev: ____ kg on ____/____/____

BMI: _____

For Children / Adolescents:

Vitals today: BP: ____ / ____ HR: ____ bpm

Weight: ____ kg Prev: ____ kg on ____/____/____

%ile today: ____ % Prev: ____ on ____/____/____

Height: ____ cm Prev: ____ cm on ____/____/____

%ile today: ____ % Prev: ____ on ____/____/____

BMI: _____

Minimum physical monitoring once stable:

HR, BP, weight (& height if < 18 yo) at least 6/12ly,

& at each significant dose change or if new symptoms arise.

Medical comorbidities & mimics:

- Medical comorbidities, interactions reviewed (e.g. HTN, cardiac history, seizures, tics, sleep apnoea, pregnancy, other psychotropics) – details: _____

CV history reviewed:

- No stimulant red flags: exertional dyspnoea, syncope, structural heart disease, arrhythmia, FHx sudden death < 40
- Cardiac hx present – Details: _____
- Any new cardiac symptoms – Details: _____

Specific monitoring plan(s):

*If on atomoxetine / a2-agonist / antipsychotic / mood stabiliser:
(e.g., LFTs, metabolic labs, BP/HR, ECG, etc.)*

- Documented monitoring plan?: Yes No
- Any new lab/red-flag issues?: Yes No

- Details / Concerns:** _____

Growth centiles / trend assessment:

Children:

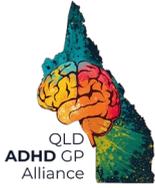
- Stable growth (following expected centile trajectory)
- Trending down <1 centile line
- Trending down ≥1 centile line → **Monitor ++**
- Drop of ≥2 centile lines → **Refer**
- Height <3rd percentile for age/sex → **Refer**
- ↓ Growth velocity <4 cm/year after 4yo → **Refer**
- Clinical concerns (pubertal delay, systemic symptoms) → **Refer**

Weight assessment:

Children:

- Stable weight trajectory
- Trending down <1 centile line
- Trending down ≥1 centile line → **Monitor ++**
- Drop of ≥2 centile lines → **Refer**
- ≥10% decrease in weight percentile → **Refer**
- Persistent downward trend despite dietary Rx → **Refer**
- Concerns (fatigue, syncope, bradycardia, psychosocial issues) → **Refer**

Adults: BMI <18.5 kg/m² (underweight) → **Refer**



9. Overall risk-benefit assessment

ADHD symptoms and functional impact:

- Much improved Moderately improved Barely improved Worse

Current overall risk (CV / psych / SUD / diversion / growth):

- Low Moderate High

Medication benefit vs harms:

- Benefits clearly outweigh risks – continue
 Benefits and risks finely balanced – adjust, monitor, closely follow-up
 Risks outweigh benefits – reduce / cease stimulant / consider non-stimulant / seek help / re-refer
 Discussed temporary medication reduction/cessation & alternative non-stimulant / non-pharmacological strategies

10. Plan

Medication plan:

- Continue current dose
 Increase to: _____
 Decrease to: _____
 Switch formulation: _____
 Consider co-morbidity management in addition:

Details: _____

- Cease stimulant; consider non-stimulant:

Details: _____

- Trial brief pt-led dose reduction / short med break
*e.g., for growth suppression, appetite issues,
or patient preference, **not** routinely mandatory*

Non-pharmacological:

- Psychoeducation
 Sleep / lifestyle interventions
 School / Uni / Workplace letter
 CBT / psychology / ADHD coaching / OT / Parent Training:

Details: _____

- Other: _____

Referrals / consultations:

- Psychiatrist review
 Paediatrician / paediatric endocrine
 ADHD expert GP
 Addiction / AOD services
 Public MH triage / acute care team
 GP Psychiatry Support Line (1800 16 17 18)

- Other: _____

Follow-up interval:

- 1–2 weeks
If unsure of how it'll go or significant adjustments needed)
 2–4 weeks
If starting to go well, some fine-tuning needed)
 2–3 months
If going really well, minimal fine-tuning needed)
 6 months
If optimised and stable, only monitoring required)

Next review booked: ____ / ____ / _____

11. Safety-netting & crisis plan

Discussed red flags / need for urgent review:

- Psychosis
 Affective switching
severe agitation / hardly sleeping at all (<4hrs recurrently)
severe irritability / euphoria
 Suicidal thoughts or escalating self-harm
 Severe chest pain / syncope / palpitations
 Safety netting provided

Disclaimer:

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

It is a supplementary resource & 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; & escalate care whenever patient safety is uncertain.

Advice provided:

- Written crisis information provided (fact sheet/link):
 Documented crisis numbers (MH triage / 000 / etc) given
 Book earlier review with myself, or usual GP, for non-urgent concerns