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: _____

<u>Outcome Measure used to evaluate progress:</u>

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*: _____

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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)

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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*

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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

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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: _____

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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 / α2-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:	**Weight 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**	**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/m^2 (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

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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: ____ / ____ / _____

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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

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