

# 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"/>	<b>Child:</b> Leaves obvious questions blank or misreads instructions on tests. <b>Adult:</b> 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"/>	<b>Child:</b> Drifts off in lessons/conversations, needs repeated redirection to task. <b>Adult:</b> 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"/>	<b>Child:</b> Teacher/parent feels they “ignore” instructions unless name is repeated. <b>Adult:</b> 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"/>	<b>Child:</b> Starts homework/chores but leaves it half-done unless supervised closely. <b>Adult:</b> 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"/>	<b>Child:</b> School bag, desk, room are messy; loses track of homework tasks. <b>Adult:</b> 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"/>	<b>Child:</b> Procrastinates homework, reading, chores, study until the last minute. <b>Adult:</b> 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"/>	<b>Child:</b> Often misplaces books, pencils, notes, sports gear at home/school <b>Adult:</b> Often loses keys, phone, wallets, pens, ID cards, important documents.
8	Easily distracted	<input type="checkbox"/>	<input type="checkbox"/>	<b>Child:</b> Looks out the window or shifts attention to every noise in the classroom. <b>Adult:</b> 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"/>	<b>Child:</b> Forgets to bring homework, permission slips or lunch; misses messages. <b>Adult:</b> 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"/>	<b>Child:</b> Constantly fidgets, taps, plays with objects at the desk. <b>Adult:</b> 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"/>	<b>Child:</b> Gets up & walks around the classroom when bored, without permission. <b>Adult:</b> 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"/>	<b>Child:</b> Excessively active “exhausting”, “full on”, “into everything”, “can’t stop”. <b>Adult:</b> Inner restlessness; strong desire to keep busy, active, “doing something”.
4	Difficulty playing or enjoying downtime quietly	<input type="checkbox"/>	<input type="checkbox"/>	<b>Child:</b> Talks loudly, struggles with quiet reading or calm games. “too boring” <b>Adult:</b> 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"/>	<b>Child:</b> “always on the go” and hard to tire out. Relentless. <b>Adult:</b> They never slow down & are constantly doing things, “hard to keep up with”
6	Talks too much	<input type="checkbox"/>	<input type="checkbox"/>	<b>Child:</b> Talks over others in class, excessive chatter home/school/everywhere. <b>Adult:</b> Keeps talking when others have moved on, waffly, rambly, long-winded.
7	Blurts out answers Interrupts	<input type="checkbox"/>	<input type="checkbox"/>	<b>Child:</b> Calls out in class before being called on; interrupts teacher’s questions. <b>Adult:</b> Finishes people’s sentences or blurts out answers, overshares.
8	Difficulty waiting turn	<input type="checkbox"/>	<input type="checkbox"/>	<b>Child:</b> Struggles to wait in queues or for their turn in games. <b>Adult:</b> Impatient in traffic, queues or discussions; visibly frustrated waiting.
9	Interrupts/Intrudes	<input type="checkbox"/>	<input type="checkbox"/>	<b>Child:</b> Butts into others’ games uninvited, interrupts conversations. <b>Adult:</b> 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

##### 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

#### 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

#### 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

##### 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: \_\_\_\_\_

### 11A. Mental State Examination

Source basis where relevant:  observed  patient-reported  inferred  mixed/unclear  not assessed

#### Appearance / behaviour

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

#### Speech / psychomotor

- Normal
- Fast / pressured / difficult to interrupt
- Slow / reduced
- Increased psychomotor activity / fidgety
- Decreased psychomotor activity / low energy

#### Mood / affect

Subjective mood:  Euthymic  Low  Anxious  Irritable

Other: \_\_\_\_\_

Affect:  Normal range  Restricted  Labile  Incongruent  Mixed/unclear

#### Thought form

- Coherent / goal-directed
- Circumstantial
- Tangential
- Flight of ideas / racing
- Other formal thought disorder: \_\_\_\_\_

### Thought content & risk

Suicidal ideation / self-harm / homicidal ideation:

Denied  Reported  Not screened  Unclear

If reported/unclear:  intent  plan  means  timeframe  protective factors  safety plan/escalation

Psychotic content / abnormal beliefs:

None evident / not reported

Possible overvalued ideas / attenuated psychotic symptoms

Clear delusional content

Not screened / unclear

### Perception

No hallucinations / perceptual disturbance reported

Possible perceptual disturbance

Clear hallucinations:  auditory  visual  other

Not screened / unclear

### 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

Mixed / context-dependent

**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.