

**GP REFERRAL FORM**

**PLEASE RETURN VIA EMAIL OR POST**

**POST: CAANI, Malone Private Clinic/ Northern MRI : 93 Malone Road, Belfast, BT9 6SP, N.Ireland**

**TELEPHONE: 07834831653 Email: info@caani.co.uk**

**Website: www.caani.co.uk**

**PATIENT DETAILS**

Name:

DOB:

Age:

Health and care Number:

Address:

Contact Telephone Number, Home/Mobile:

Persons with Parental Responsibility:

**G.P. DETAILS GP PRACTICE STAMP**

**GP Name:**

N.B. PLEASE ADVISE IF YOUR PRACTICE IS AGREEABLE TO WORKING WITH US TO PRESCRIBE ADHD MEDICATION (SHOULD SAME BE INDICATED) IN A MODEL SIMILAR TO SHARED CARE BUT BY ARRANGEMENT WITH CAANI AS SPECIALIST PROVIDER **YES/NO**

IF NO, IS PARENT/CARER AWARE OF COSTS AND COMPLEXITIES OF PRIVATE CONTROLLED DRUG SCRIPTS? **YES/NO**

**Address:**

**Contact Telephone Number:**

**FAX NO:**

**Email Address**

**Patients Method Of Funding: Private Health Insurance or Self-Funding (Please Circle )**

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| **Reason For Referral/Current symptoms and/or concerns reference possible ADHD** | **PAST MEDICAL & PSYCHIATRIC HISTORY** |
| **Current Medication** | **Drug Allergies** |
| **Relevant Medical Investigations To Date :**  **E.g. CT/MRI brain scan, Blood results, ECG. Please attach if possible**. | **Risks Previous and Current** :  Self –Harm YES/NO please circle  Self Neglect YES/NO please circle  Harm to OTHERS YES/NO please circle  OTHER RISKS |
| **Previous History of Alcohol or Substance Misuse** | **Current Social Circumstances** |
| **PAST MEDICAL HISTORY** | **PREVIOUS PAEDIATRIC/CAMHS /AUTISM SERVICE ASSESSMENT OR INPUT** |

THANK-YOU FOR YOUR REFERRAL