



Patient Name:

Date of Birth:

Physician Name:

MRN/File No:

Date:

CADDRA ADHD ASSESSMENT FORM

Identifying Information

Patient:		Date of Birth:	Date seen:
Age:	Gender: <input type="checkbox"/> m <input type="checkbox"/> f	Grade (actual/last completed):	
Current Occupation: <input type="checkbox"/> student <input type="checkbox"/> unemployed <input type="checkbox"/> disability occupation:			
Status: <input type="checkbox"/> child/adolescent <i>OR</i> adult <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> common-law <input type="checkbox"/> separated <input type="checkbox"/> divorced			
Ethnic Origin: (<i>check all that apply</i>) <input type="checkbox"/> Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> African-American <input type="checkbox"/> Native			
Other person providing collateral:			Patient's phone no:

Demographics

	Biological Father (if known)	Biological Mother (if known)	Spouse/Partner (if applicable)
Name			
Occupation			
Highest education			
Adopted: <input type="checkbox"/> No <input type="checkbox"/> Yes	Age of Adoption:	Country of Adoption:	
Number of biological and/or half siblings:			
	Stepfather (if applicable)	Stepmother (if applicable)	Other Guardian (if applicable)
Name			
Occupation			
Highest education			
Number of step-siblings:			
Custody (circle custodial parent)	Time with bio Father	Time with bio Mother	Time with step family
Language	At home: <input type="checkbox"/> English <input type="checkbox"/> Other _____ <input type="checkbox"/> At school _____		
Children (if applicable)	Number of biological:	Number of step children:	
Names and ages			

Patient Name:	
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Physician Name:	Date:

Medical History

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes (Details):
Cardiovascular medical history: <input type="checkbox"/> hypertension <input type="checkbox"/> tachycardia <input type="checkbox"/> arrhythmia <input type="checkbox"/> dyspnoea <input type="checkbox"/> fainting <input type="checkbox"/> chest pain on exertion <input type="checkbox"/> other
Specific cardiovascular risk identified: <input type="checkbox"/> No <input type="checkbox"/> Yes (Details):
Positive lab or EKG findings:

Positive medical history:	<input type="checkbox"/> In utero exposure to nicotine, alcohol or drugs	<input type="checkbox"/> Stigmata of FAS/FAE	<input type="checkbox"/> History of anoxia/perinatal complications
<input type="checkbox"/> Developmental delays	<input type="checkbox"/> Coordination problems	<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Lead poisoning
<input type="checkbox"/> Neurofibromatosis	<input type="checkbox"/> Myotonic dystrophy	<input type="checkbox"/> Other genetic syndrome	<input type="checkbox"/> Hearing/visual problems
<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Growth delay	<input type="checkbox"/> Anemia
<input type="checkbox"/> Traumatic brain injury	<input type="checkbox"/> Seizures	<input type="checkbox"/> Enuresis	<input type="checkbox"/> Injuries
<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Tourette's/tics	<input type="checkbox"/> Enlarged adenoids or tonsils	<input type="checkbox"/> Asthma
<input type="checkbox"/> Sleep disorders	<input type="checkbox"/> Secondary symptoms to medical causes	<input type="checkbox"/> Medical complications of drug/alcohol use	
Other/details:			

Medication History

Extended health insurance: <input type="checkbox"/> No <input type="checkbox"/> Yes (Details):			
<input type="checkbox"/> Public <input type="checkbox"/> Private insurance		Coverage for psychological treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Adherence to treatment/attitude towards medication: Difficulty swallowing pills: <input type="checkbox"/> No <input type="checkbox"/> Yes (If applicable) Contraception: <input type="checkbox"/> No <input type="checkbox"/> Yes (Details):			
Current medications	Dose	Duration Rx	Outcome and side effects
Previous medications	Dose	Duration Rx	Outcome and side effects

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Date:

Physical Examination

Practice guidelines around the world recognize the necessity of a physical exam as part of an assessment for ADHD in order to rule out organic causes of ADHD, rule out somatic sequelae of ADHD, and rule out contraindications to medications. While this physical exam follows all the usual procedures, several specific evaluations are required. These include, but are not limited to:

Rule out medical causes of ADHD-like symptoms

- Hearing and vision assessment
- Thyroid disease
- Neurofibromatosis (cafe au lait spots)
- Any potential cause of anoxia (asthma, CF, cardiovascular disease)
- Genetic syndromes and facial or dysmorphic characteristics
- Fetal alcohol syndrome: growth retardation, small head circumference, smaller eye openings, flattened cheekbones and indistinct philtrum (underdeveloped groove between nose and upper lip)
- Physical abuse: unset fractures, burn marks, unexplained injuries
- Sleep disorders: enlarged tonsils and adenoids, difficulty breathing, sleep apnea
- Growth delay or failure to thrive
- PKU, heart disease, epilepsy and unstable diabetes can all be associated with attention problems
- Head trauma.

Medical history/lab work provides information on maternal drinking in pregnancy, sleep apnea, failure to thrive, lead poisoning, traumatic brain injury.

Rule out sequelae of ADHD

- Abuse
- High pain threshold
- Irregular sleep, delayed sleep phase, short sleep cycle
- Comorbid developmental coordination disorder, evidenced by motor difficulties in doing routine tasks such as getting on the exam table
- Picky eater: will not sit to eat
- Evidence of injuries from poor coordination or engagement in extreme sports

Rule out contraindications to medication:

- Glaucoma
- Uncontrolled hypertension
- Any evidence of significant cardiovascular abnormality

Date of last physical exam:	By who:
Abnormal findings last exam:	

Current Physical Exam

System	Done		Normal		Findings (Details of Abnormality)
	No	Yes	No	Yes	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
GI and GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cerebrovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Immunol. & Hematological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrinological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dysmorphic facial features	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Weight: In children: percentile	Height: In children: percentile	Head Circum: (In children only)	BP:	Pulse:
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Positive Findings on Observation: (Details)
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Psychiatric History

Assessed in childhood/adolescence/adulthood? <input type="checkbox"/> No <input type="checkbox"/> Yes		By whom:
Previous diagnoses:		
Previous suicidal attempts or violent gestures toward others: <input type="checkbox"/> No <input type="checkbox"/> Yes	Details:	
Psychological treatments: <input type="checkbox"/> No <input type="checkbox"/> Yes		
Previous psychiatric evaluation/hospitalization: <input type="checkbox"/> No <input type="checkbox"/> Yes		

Developmental History

Pregnancy Problems: <input type="checkbox"/> No <input type="checkbox"/> Yes Delivery <input type="checkbox"/> on time <input type="checkbox"/> Early (# of weeks: _____) <input type="checkbox"/> Late (# of weeks: _____) <input type="checkbox"/> forceps used <input type="checkbox"/> Caesarean section <input type="checkbox"/> breech	Details:
Difficulties gross motor: crawl, walk, two-wheeler, gym, sports: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Difficulties Fine motor: tracing, shoe laces, printing, writing: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Language difficulties: first language, first words, full sentences, stuttering <input type="checkbox"/> No <input type="checkbox"/> Yes	
Odd behaviours noted: (e.g. rocking, flapping, no eye contact, odd play, head banging etc) <input type="checkbox"/> No <input type="checkbox"/> Yes	
Temperament: (eg. difficult, willful, hyper, easy, quiet, happy, affectionate, calm, self soothes, intense)	
Parent description of child's temperament:	
Learning Disorder identified: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> dyslexia <input type="checkbox"/> dysorthographia <input type="checkbox"/> dyscalculia <input type="checkbox"/> dsyphasia <input type="checkbox"/> other: _____	

Family History in First Degree Relatives

Childhood temperament of the biological parents, if known: (e.g. internalizing versus externalizing)	
Father:	Mother:
Positive family history of:	
<input type="checkbox"/> ADHD (probable) <input type="checkbox"/> Autism Spectrum Disorders <input type="checkbox"/> Bipolar <input type="checkbox"/> Sleep Disorders <input type="checkbox"/> Legal Convictions	<input type="checkbox"/> ADHD (confirmed) <input type="checkbox"/> Congenital Disorders <input type="checkbox"/> Psychosis <input type="checkbox"/> Tourette's/Tics
<input type="checkbox"/> Learning Disorders <input type="checkbox"/> Anxiety <input type="checkbox"/> Personality Disorders <input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mental Retardation <input type="checkbox"/> Depression <input type="checkbox"/> Suicide <input type="checkbox"/> Alcohol/Drug Problems
<input type="checkbox"/> History of early cardiac death	<input type="checkbox"/> Known arrhythmias <input type="checkbox"/> Hypertension
Details:	

Functioning and Lifestyle Evaluation

General Habits (depending on the subject's age, some may not apply). Give frequency and/or details:			
Exercise			
Nutrition			
Self care, personal hygiene			
Adequate leisure activity			
Sleep Routine and Quality of Sleep	Bedtime: # Sleep hours:	Time to fall asleep: Melatonin: <input type="checkbox"/> No <input type="checkbox"/> Yes Dose:	Wake up time:
Sleep Problems? (BEARS)	Bedtime resistance: <input type="checkbox"/> No <input type="checkbox"/> Yes Excessive daytime sleepiness: <input type="checkbox"/> No <input type="checkbox"/> Yes Awakening: <input type="checkbox"/> No <input type="checkbox"/> Yes	Regularity: <input type="checkbox"/> No <input type="checkbox"/> Yes Snoring: <input type="checkbox"/> No <input type="checkbox"/> Yes	

Important Risk Factors to Identify

Risk Factor	No	Yes	Details and Attitude towards Change
Excessive screen time	<input type="checkbox"/>	<input type="checkbox"/>	
Accident-prone	<input type="checkbox"/>	<input type="checkbox"/>	
Extreme sports	<input type="checkbox"/>	<input type="checkbox"/>	
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	
Financial	<input type="checkbox"/>	<input type="checkbox"/>	
Driving	<input type="checkbox"/>	<input type="checkbox"/>	
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	
Parenting	<input type="checkbox"/>	<input type="checkbox"/>	
Family conflict	<input type="checkbox"/>	<input type="checkbox"/>	
Legal	<input type="checkbox"/>	<input type="checkbox"/>	
Discipline	<input type="checkbox"/>	<input type="checkbox"/>	
Witness to violence	<input type="checkbox"/>	<input type="checkbox"/>	
Trauma	<input type="checkbox"/>	<input type="checkbox"/>	
Physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Foster placements	<input type="checkbox"/>	<input type="checkbox"/>	
Significant losses	<input type="checkbox"/>	<input type="checkbox"/>	
Illness	<input type="checkbox"/>	<input type="checkbox"/>	

Current Functioning at Home (depending on age, some may not apply). Give frequency and/or details:	
Family/patient strengths	
Stressors within the family	Past:
	Present:
Family atmosphere	
Morning routine	
Attitudes towards chores (adult: doing housework)	
Attitudes towards rules (adult: able to set/follow rules)	
Engagement in family fun	
Discipline in the family (adult: parenting abilities)	
Relationship to siblings (adult: partner relationship)	
Parent/spouse frustrations	

Social Functioning (depending on age, some may not apply). Give frequency and/or details:	
Patient's strengths:	
Hobbies, activities	
Friends (e.g. play dates, parties, social events)	
Social skills (e.g. social cues compassion, empathy)	
Humour	
Anger management (e.g. aggression, bullying)	
Emotional intelligence (e.g. emotional control, awareness)	
Sexual identity	

Functioning at School (if not at school, indicate where academic history took place and if there were difficulties)		
School name	<input type="checkbox"/> English Second Language <input type="checkbox"/> Individual Education Plan <input type="checkbox"/> Specialized Class <input type="checkbox"/> Specialized Designation Details:	
	Kindergarten to Grade 8	High School
Report card grades		
Report card comments		
Behaviour problems		
Peer relations		
Teacher-child relationships		
Teacher-parent relationships		
Homework attitudes		
Organizational skills		
Achieving potential/difficulties		
Written output		
Accommodations		
Tutoring and/or Learning assistance		
Assistive Technology		
College/University		
Accommodations		
Achieving potential/difficulties		

Functioning at Work (depending on the subject's age, some may not apply) Frequency and/or details:	
Current employment status:	<input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Unemployed <input type="checkbox"/> Self-employed <input type="checkbox"/> Contract <input type="checkbox"/> Disability
Vocational Assessment:	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, suitable jobs:
# of past jobs:	Length of longest employment:
Work strengths:	
Work weaknesses:	
Complaints:	
Workplace accommodations:	
Other information about work:	

RATING SCALES: Administer one or more of the relevant rating scales to the parent, teacher or patient

STEP ONE: Check the ADHD scale(s) used

ADHD symptoms in childhood:	<input type="checkbox"/> ADHD Checklist	<input type="checkbox"/> SNAP-IV	<input type="checkbox"/> Other
Current ADHD symptoms:	<input type="checkbox"/> ADHD Checklist <input type="checkbox"/> SNAP- IV (for children)	<input type="checkbox"/> Weiss Symptom Record (WSR) <input type="checkbox"/> ASRS (for adults)	<input type="checkbox"/> Other

The ADHD Checklist can retrospectively be used to assess childhood ADHD symptoms (in adults), for current symptoms and for follow-up (all ages)

STEP TWO: Fill in the result of the scale

SYMPTOM SCREENER (enter the number of positive items for each category, circle the box if the threshold was met or if ODD or CD is a concern)					
Retrospective Childhood symptom screen	IA /9	HI /9	ODD /8	CD* /15	
Current					
Parent	IA /9	HI /9	ODD /8	CD* /15	
Self	IA /9	HI /9	ODD /8	CD* /15	
Teacher	IA /9	HI /9	ODD /8	CD* /15	
Collateral	IA /9	HI /9	ODD /8	CD* /15	
Other comorbid dx*					

* Conduct disorder and other comorbid disorder only applies to the WSR

FOR ADULTS: The Adult ADHD Self Report Rating Scale (ASRS) can be used for current ADHD symptoms, part A being the screener section

ADULT ADHD SELF REPORT RATING SCALE (ASRS) (record the number of positive items for Part A and Part B, circle the box where threshold is made)	
Part A (Threshold > 4)	/6
Part B	/12

STEP THREE: Administer the Weiss Functional Inventory Rating Scale (WFIRS)

WEISS FUNCTIONAL INVENTORY RATING SCALE (WFIRS) (record the number of items rated 2 or 3, circle the boxes where you perceive a problem)							
Parent	Family /10	School (learning) /4	(behaviour) /6	Life Skills /10	Self /3	Social /7	Risk /10
Self	Family /8	Work /11	School /10	Life Skills /12	Self /5	Social /9	Risk /14

OTHER SCALES	

Psychometric Evaluation – Done? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Requested		Date(s) of Testing:	
Intelligence Tests Score:		<input type="checkbox"/> marked below <input type="checkbox"/> borderline <input type="checkbox"/> low average <input type="checkbox"/> average	
<input type="checkbox"/> above average <input type="checkbox"/> marked above <input type="checkbox"/> superior			
WISC or WAIS (%ile or scaled score)	Verbal Comprehension	Perceptual Reasoning	Working Memory
			Processing Speed
Older IQ tests used %ile/IQ Full Scale IQ Verbal IQ Performance IQ			
Achievement tests Score: -2 (>2 yrs below) -1 (1-2 yrs below) 0 (grade level) +1 (1-2 yrs above) +2 (>2 yrs above)			
Grade level:	Reading	Spelling	Math
			Writing

MENTAL STATUS EXAMINATION (clinical observations of the interview)

SUMMARY OF FINDINGS

(This allows a clinician reflect on the global collection of information in readiness for the diagnosis, feedback and treatment)

Item of Relevance	N/A	Does not indicate ADHD	Marginally indicates ADHD	Strongly indicates ADHD	Comments
Symptoms of ADHD in childhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Current ADHD symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Collateral information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clinical observation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family history of diagnosed first degree relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Review of school report cards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Previous psychiatric assessments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychometric/psychological assessments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	N/A	Suggesting an alternative explanation is better	ADHD is possible but other factors relevant	ADHD is still the best explanation of findings	Comments
In utero exposure to substances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neonatal insult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infant temperament	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental milestones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychosocial stressors before 12					
Accidents and injuries (particularly head injury)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Major trauma before age 12 (e.g. abuse-physical, sexual, neglect)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Substance use history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other medical problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

DIAGNOSIS

Note: This table helps the clinician understand how the DSM-IV-TR records axial information

Axis I: Actual diagnosis and any learning disabilities

Axis II: Mental retardation, developmental delay and any personality disorders (traits if sub-threshold for an actual disorder)

Axis III: Any medical disorders or any past medical disorders that might be important to note

Axis IV: Severity of psychosocial stressors: Name the stressors and indicate their severity from Mild, Moderate, Severe

Axis V: Global Assessment of Functioning: This is a number given (from the table below) that helps to monitor functioning over time. This is a quick way of being able to record clinical progress.

Axis V	CGAS Anchor Points	Score
91-100	Superior functioning in all aspects of life; active, likeable, confident	
90-81	Good functioning in school, home, peers, transient everyday worries have mild reaction	
80-71	Slight impairment in school, home or peers, transient behaviour and emotional reaction	
70-61	Difficulty in an area of life but functioning well (mood change, sporadic anti-social act)	
60-51	Variable functioning and sporadic difficulties in several areas of life, apparent to others	
50-41	Moderate interference in functioning or severe impairment in school, home or peers	
40-31	Major impairment; unable to function in one area (suicide attempt, persistent aggression, marked withdrawal and isolation, severe mood or thought disturbance)	
30-21	Unable to function in life, severe impairment in communication and reality testing	
20-11	Needs supervision to be safe and for self-care, gross impairment in communication	
10-0	Needs 24 hour supervision for severe aggressive, self-destructive behaviour, affect, thought, reality testing, communication impairment.	

Diagnosis following DSM:

Axis I: DSM Diagnoses

Axis II: Personality/Developmental delay

Axis III: Medical conditions

Axis IV: Stressors (mild, moderate, severe)

Axis V: Global Assessment of Functioning

Important Lifestyle Issues:

Treatment Plan

Patient Name: _____ MRN/File No.: _____

	N/A	To Do	Done	Referred to and comments/Details
Psychoeducation				
Patient Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Parent Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Info to School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Handouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Medical				
Physical Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CV Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Baseline Ratings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lab Investigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pharmacological Interventions				
Review Medication Options	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Medication Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Non Pharmacological Interventions				
Psychological Testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social Skills Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anger Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Addiction Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cognitive Behaviour Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Parent Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OT Referral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Educational & Vocational				
Psychoeducational Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Special Education/Accommodations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vocational Assessments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Workplace Accommodations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Completion of Special Forms				
CRA Tax Credits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Physician Signature: _____ Date: _____
 Copy sent to: _____ Fax No: _____