CADDRA
CANADIAN ADHD RESOURCE ALLIANCE

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| Patient Name: | |
| Date of Birth: | MRN/File No: |
| Physician Name: | Date: |

# CADDRA Teacher Instructions

Name of the educator: _____

Name of the student: _____ Date: _____

Number of hours spent with the student per week: _____

Time period for which the form was filled out: _____

Hello,

Your student, _____, is presently under medical evaluation. To assist with this process, his/her doctor would appreciate your observations on his/her functioning in class. Your feedback will be important in providing knowledge of the student's functioning in the school setting.

As his/her teacher, you are a key part of his/her learning process. We thank you for your input and your assistance in better assessing the needs of this student. The objectives of these forms are to reach an accurate diagnosis and offer interventions and therapeutic solutions that will be individualized for this student.

If you are unsure of your response, go with your first instinct. Do not leave any items blank.

## Questionnaires

Please complete:

- ☐ CADDRA Teacher Assessment Form
- ☐ Weiss Symptom Record
- ☐ SNAP-IV 26 or ADHD Checklist

## Please use this section for other details or comments you would like to provide to your student's doctor:

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