Patient Name:	
Date of Birth:	MRN/File No:
Physician Name:	Date:
Contact Number:	

CADDRA ADHD PATIENT TRANSITION FORM

Additional physicians and services involved in care:

Medication (Current & Past)	**Current ✓**	**Current Dose Max Dose Trialed**	**Trial Length**	**Reason for stopping medication**
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			

Adherence to Treatment. Comments:

Height:	Weight:	Blood Pressure:	Pulse:

Comorbidities ✓	☐ Anxiety Disorder	☐ Mood Disorder	☐ Conduct Disorder	☐ Oppositional Defiant Disorder	☐ Tic Disorder
☐ Learning Disorder	☐ Autism Spectrum Disorder	☐ Language Disorder	☐ Personality Disorder/Traits	☐ Intellectual Disability	☐ Fetal Alcohol Syndrome
☐ Substance Use Disorder	☐ Other				

Comments:

ADHD Impairment Severity: ☐ Mild ☐ Moderate ☐ Severe

Comments:

Medical Diagnosis:

Treatment plan:

Signature: Date:

Copy to be sent to: