CANADIAN ADHD RESOURCE ALLIANCE

Patient Name: _____

Date of birth: _____ **MRN/File #:** _____

Clinician's Name: _____ **Date:** _____

CADDRA ADHD PATIENT TRANSITION FORM

Additional clinician(s) 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: _____

PRINT