CADDRA ADHD PATIENT TRANSITION FORM

Additional clinician(s) and services involved in care

<table>
<thead>
<tr>
<th>Medication (Current &amp; Past)</th>
<th>Current</th>
<th>Current Dose</th>
<th>Max Dose Traled</th>
<th>Trial Length</th>
<th>Reason for stopping medication</th>
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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: ___________________________