Additional Helpful Information Form
(To support your ADHD Right to Choose referral)

Patient Name……

Date of Birth……

Date Completed ……

1. Current Mental Health Support

Please indicate any services you are currently receiving support from:

Talking Therapies / IAPT Yes ☐ No ☐

If yes, please provide details

Community Mental Health Team (CMHT) Yes ☐ No ☐

If yes, please provide details

Crisis Team / Crisis Café / Home Treatment Team Yes ☐ No ☐

If yes, please provide details

Counselling or private therapy Yes ☐ No ☐

If yes, please provide details

Any recent crisis-line contact (e.g., 111, Samaritans, SHOUT):

Details (optional):

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2. Previous ADHD or Neurodevelopmental History (if applicable).

Please provide any previous assessments, diagnoses, or reports:
