

ATTENTION DEFICIT HYPERACTIVITY EVALUATION

Name _____ DOB _____ Date of Visit _____

Physical Findings: T _____ P _____ R _____ BP _____ Nurse Initials _____

Clinical Evaluation:

- Summary of Clinical Evaluation—Attach supporting documentation _____

- ADHD Rating Scale(s) (Connors, ASRS, CAARS) scores and report summary—Attach supporting documentation _____

- Alternative non-banned medication considered and comments _____

- Additional Evaluation Information (Lab results, Psychological testing results, physical exam etc.): _____

Diagnosis: _____

Medication(s) and dosage: _____

Follow-up: _____

Physician Name (Printed): _____

Office Address: _____

Specialty: _____

Signature _____