Right to Choose

Neurodevelopmental lifespan services

Attention deficit hyperactivity disorder (ADHD) assessment report

**REPORT DETAILS**

| Assessment date(s) | ##/##/#### |
| --- | --- |
| Report date | ##/##/#### |
| Clinical team | YYY (Paediatrician)  YYY (Child & Adolescent Psychiatrist)  YYY (Clinical Psychologist)  YYY (Specialist ADHD Nurse) |
| Report sent to: | Parent/Carer |
| GP |
| If applicable and consent sought, clinician to add any other name/email here for report to be sent to (e.g. social worker) |

This report aims to provide greater understanding of XXX’s experiences, strengths, and challenges, and to explore whether a diagnosis may help explain their unique profile. It is based on the information available at the time of the assessment. This assessment was not conducted for medico-legal purposes and, as such, is not intended for use in that context.

**CLIENT DETAILS**

| First name | XXX |
| --- | --- |
| Surname | QQQQ |
| Age at assessment | QQ y QQ m |
| Date of birth | ##/##/#### |
| NHS number | QQQQ |
| Client ID | QQQQ |
| Address | QQQQ |

**ASSESSMENT OUTCOME**

{{Assessment\_Outcome}}

*(Diagnosed)*

All the information and reports for XXX have been carefully considered, including observations of interactions during the assessment. The conclusion is that XXX’s unique patterns of thinking and behaviour are best understood in relation to ADHD.

The features identified align with the DSM-5 criteria for a diagnosis of ADHD (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, APA, 2013). The DSM-5 diagnostic criteria are met when a person exhibits persistent patterns of inattention and/or hyperactivity-impulsivity, which are present from before the age of 12 years and are impacting significantly on different areas of their life. Their difficulties cannot be better explained by a mental health condition or another neurodevelopmental condition.

**It is my opinion that XXX meets criteria for ADHD.** A summary of the evidence gathered against the criteria is presented in the following report.

It is important to note that many people prefer to use the term ‘difference’ rather than ‘disorder’. XXX and their parent/carers may choose to use this terminology when describing their distinct characteristics.

*(Not diagnosed)*

All the information and reports for XXX have been carefully considered, including observations of interactions during the assessment. The conclusion is that XXX’s unique patterns of thinking and behaviour may relate to certain aspects of ADHD, but they do not fully meet the criteria for an ADHD diagnosis.

The features looked at come from the DSM-5 criteria for ADHD (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, APA, 2013). According to these criteria, a diagnosis is made when a person exhibits persistent patterns of inattention and/or hyperactivity-impulsivity, which are present from before the age of 12 years and are impacting significantly on different areas of their life. Their difficulties cannot be better explained by a mental health condition or another neurodevelopmental condition.

**It is my opinion that XXX does not meet criteria for ADHD.** A summary of the evidence gathered against the criteria is presented in the following report.

Although XXX has not received a formal diagnosis, this does not diminish the challenges they are experiencing. I fully acknowledge their difficulties and have provided recommendations for the next steps, which I hope will be helpful.

**ASSESSMENT INFORMATION**

Psicon was commissioned to carry out an attention deficit hyperactivity disorder (ADHD) assessment.

The assessment offered by Psicon consists of the completion of a Conners questionnaire (a screening tool for ADHD) by the child’s parent/carer and school. This is then followed by an appointment with a specialist clinician with expertise in ADHD who takes a developmental history, evaluates the available evidence, and makes a decision in regard to diagnosis and future plan.

Clinician to complete (select **one** of two)

* The assessment was carried out face-to-face. The developmental history information was collected from XXX’s mother/father/OTHER.
* The assessment was carried out via video consultation. The developmental history information was collected from XXX’s mother/father/OTHER.

Clinician to add in how this particular session was set up: explain who was present and how the session was structured (e.g. family and young person all met together and were present for the duration of the session OR the young person attended the first part of the session, with parents, but left for the second half, before joining for feedback etc). \*Must\* include reference to meeting the child

{{Assessment\_Information}}

**WHO WE ASSESSED**

Positive connotation only – e.g. strengths, character, positive traits, likes/dislikes, special interests/passions, positive behaviour during the assessment process, positive family connections/relationships

{{Who\_We\_Assessed}}

**CONSENT**

{{Consent}}

Clinician to complete (select **one** of two)

* Parent/carer provided their consent for the assessment to take place.
* (Gillick competent) The structure of the session was explained to XXX and they confirmed they understood the purpose of the appointment and consented for the assessment to take place.

**UNDERSTANDING OF APPOINTMENT**

Include parent’s understanding of the appointment and expectations, include child’s understanding of the appointment (if age relevant)

{{Understanding\_of\_Appointment}}

**REASON FOR REFERRAL AND PRESENTING CONCERNS**

Include what and when were the first concerns; Include current concerns from parent/carer and school perspective; Include child’s perspective (if age relevant) e.g. how are things going at school for them

{{Reason\_for\_Referral\_and\_Presenting\_Concerns}}

**PAST MEDICAL HISTORY**

Include pregnancy, birth history, allergies, current medication, hearing, vision, hospital admissions, involvement with other specialist health services e.g. paediatric team, speech and language etc.

{{Past\_Medical\_History}}

**EARLY DEVELOPMENTAL HISTORY**

Include infant development, speech development, motor skills development, toilet training, play

{{Early\_Developmental\_History}}

**FAMILY AND SOCIAL HISTORY**

Include household details, mental and physical health of family members, significant life events, reference current or previous involvement with social care and/or Early Help

{{Family\_and\_Social\_History}}

**MENTAL HEALTH AND WELLBEING**

Include anxiety and mood, any prior or current mental health services input

{{Mental\_Health\_and\_Wellbeing}}

**CURRENT DEVELOPMENT AS REPORTED BY PARENT/GUARDIAN**

***Attention & Concentration***

Consider the DSM-5 criteria and reference examples from both home and school

* Fails to give close attention to details or makes careless mistakes.
* Difficulty sustaining attention in tasks or play activities.
* Does not seem to listen when spoken to directly.
* Does not follow through on instructions and fails to finish tasks.
* Easily distracted by extraneous stimuli.
* Forgetful in daily activities.

{{ADHD\_Featured\_Inattention}}

***Activity Levels***

Consider the DSM-5 criteria and reference examples from both home and school

* Fidgets with or taps hands/feet or squirms in seat.
* Leaves seat in situations when remaining seated is expected.
* Runs about or climbs in inappropriate situations (or feels restless in older children and adults).
* Unable to play or engage in leisure activities quietly.
* Appears to be "on the go" or acts as if "driven by a motor."
* Talks excessively.

{{ADHD\_Features\_Hyperactivity}}

***Impulsivity***

Consider the DSM-5 criteria and reference examples from both home and school

* Blurts out answers before questions have been completed.
* Difficulty waiting their turn.
* Interrupts or intrudes on others
* Danger awareness

{{ADHD\_Features\_Impulsivity}}

***Executive Functioning & Organisational***

Consider the DSM-5 criteria and reference examples from both home and school

* Difficulty organizing tasks and activities.
* Avoids or dislikes tasks that require sustained mental effort.
* Frequently loses things necessary for tasks.

[type here]

***Emotional & Behavioural Regulation***

Reference at home/in relationships/in primary school/in secondary school/in nursery or college (if applicable)

[type here]

***Self-Care & Independence***

Include personal hygiene, eating and sleeping habits

{{Self\_Care\_and\_Independence}}

{{Diet\_and\_Growth}}

{{Sleep}}

***Social Communication & Interaction***

Include social reciprocity, non-verbal communication and relationships, language and social skills

{{Social\_Functioning}}

***Friendships & Relationships***

Include how others perceive the child, empathy and emotional intelligence

[type here]

***Restricted & Repetitive Behaviours and Interests/Activities***

Include repetitive behaviours, routines, resistance to change, special interests, sensory sensitivities

{{Restrictive\_and\_Repetitive\_Interests}}

**EDUCATION**

Include nursey, primary school, secondary school and college (if applicable), general academic performance, teacher feedback/summarise school report

[type here]

**OBSERVATIONS FROM CLINICAL INTERVIEW**

Include observations during clinical interview/developmental history (e.g. how they interacted with clinician during the session, their response to the session etc.)

Detail any physical features that may need follow up (e.g. dysmorphic facial features)

{{Observations\_from\_Clinical\_Interview}}

**WHY DID WE DIAGNOSE? / WHY DID WE NOT DIAGNOSE?** (pick **one** of two headings)

The assessment aimed to rule out or confirm a diagnosis of ADHD. Our conclusion is that **XXX meets / does not meet** the criteria for this condition.

Insert brief formulation of why the diagnostic criteria was met or not met. \*Must\* include reference to:

* screening measures
* school report
* observations from clinical interview/developmental history
* developmental history
* QB test/check if applicable

If diagnosed - \*must\* reference type of ADHD – predominantly inattentive, predominantly hyperactive, or combined and \*must\* justify

If NOT diagnosed, \*must\* include examples from the diagnostic criteria that are not in line with a diagnosis and can be seen as falling outside of ADHD functioning, as well as acknowledging those that may be in line

If NOT diagnosed, \*must\* include a rationale of why not diagnosed if conners/QB was over threshold and/or school report was suggestive

{{Diagnostic\_Conclusion}}

**NOT DIAGNOSED: MOVING FORWARD***[delete section if not applicable]*

We have discussed the outcome of this assessment and offered the rationale for the decision that was made. We recommend that the family read through the materials enclosed/attached to this report.

Although a diagnosis of ADHD has not been given, this does not diminish the challenges faced by this young person and their family. The absence of a diagnosis does not mean an absence of attention-related or executive functioning difficulties, and we recognise that reaching this point in the process may have taken time. It is completely understandable that coming to the end of the assessment pathway without a definitive explanation can feel frustrating or disappointing.

Ruling out ADHD can be just as valuable as receiving a diagnosis, as it helps narrow down the possibilities and guide the next steps. Some young people may display traits associated with ADHD—such as inattention, impulsivity, or hyperactivity—but these may not be significant enough, or consistently present across multiple settings, to meet the criteria for a diagnosis. In other cases, there may be different explanations for a young person’s presentation. Anxiety, low mood, trauma, and other forms of psychological distress can sometimes lead to difficulties with focus, restlessness, or emotional regulation, making it essential to consider a wide range of factors. Additionally, other neurodevelopmental conditions—such as autism or specific learning difficulties—share overlapping characteristics with ADHD, and concerns around processing speed, working memory, or emotional well-being may also contribute to the way a young person presents.

We strongly encourage ongoing conversations with your GP and the school to explore the best ways to support this young person. While a diagnosis can be helpful, their needs go beyond a label, and the most important outcome is understanding how to meet those needs effectively.

Each school may approach student support differently, and sharing this report with them will provide valuable insights into how best to meet this young person’s needs, regardless of diagnosis. Open discussions with the school can help create the right support plan moving forward.

If you need any further guidance, please do not hesitate to contact us. We are here to support you in finding the next step on this journey.

**DIAGNOSIS: MOVING FORWARD** *[delete section if not applicable]*

We have discussed the outcome of this assessment and offered the rationale for the decision that was made. We have signposted to local services and other sources of further information and support. We recommend that the family read through the materials enclosed/attached to this report.

Every child and young person with ADHD will have a range of skills and abilities. They will also have individual needs that require us to adapt our teaching and environment so that they can thrive.

ADHD can potentially impact on a young person’s capacity to access and thrive in education. Specific recommendations for school or education are beyond the scope of this clinical diagnostic assessment and each school will have a unique policy on offering support to those young people who have additional needs. The outcome of this assessment should be discussed with school to establish what support is needed and the following suggestions should be considered.

To help a child reach their full potential and develop in a way that works best for them, it may be helpful to further understand their brain and the way it works. We recommend that all parent/carers attend a post-diagnosis workshop. To find a programme in your area, search your council’s “local offer”. If you're not ready immediately after the assessment, you can always refer later.

**RECOMMENDATIONS AND FURTHER CONSIDERATIONS**

[Admin: **remove** **purple prompts and headings**, flag any actions]

[Clinician: only keep recommendations that are applicable. Complete any red prompts]

The following are tailored recommendations based on concerns discussed.

***Autism Screening***

1. ***If only referred for ADHD assessment initially:*** Parent/guardian mentioned that XXX shows [a strong preference for routines and becomes distressed with minor changes]. The school report also noted [repetitive behaviours, sensory sensitivities, and difficulty understanding social cues]. Observations from today’s assessment (e.g. no eye contact and limited facial expressions) also suggest that XXX may benefit from screening for autism. Should parent/carer wish to consider further assessment, they are advised to discuss a new referral with their GP.
2. ***If referred for DUAL assessment initially but declined for autism:*** While XXX was originally declined for a dual assessment based on initial screeners measures, observations from today’s assessment suggest that an autism assessment may be appropriate. For example, parent/guardian mentioned that XXX shows [a strong preference for routines and becomes distressed with minor changes]. The school report also noted [repetitive behaviours, sensory sensitivities, and difficulty understanding social cues]. In the clinic, XXX [did not hold eye contact]. Should parent/carer wish to continue with an autism assessment, they can email [righttochoose@psicon.co.uk](mailto:righttochoose@psicon.co.uk) (including their child’s full name and DOB) to request that the autism referral be re-opened.

***ADHD Medication***

1. ***Mild/moderate ADHD*** - Following the diagnosis, you may wish to search your “local offer” to see if there are any post-diagnostic programmes or educational workshops available in your area. We advise that ADHD behavioural strategies are implemented at home and school in the first instance (see attachment for further resources). Following this, family can contact Psicon to consider medication. To do so, email [ADHDappointments@psicon.co.uk](mailto:ADHDappointments@psicon.co.uk) (including their full name and DOB) to request to be added to the medication wait list. The current estimated wait time is approximately 3 months from the date of request. While a new referral will not be needed, depending on the length of time between your assessment and request, we may need to contact your GP to confirm any health changes.
2. ***Moderate-severe ADHD***- Given the diagnosis and ongoing difficulties, family expressed interest in exploring medication as a treatment option. Should they wish to pursue this, they can email [ADHDappointments@psicon.co.uk](mailto:ADHDappointments@psicon.co.uk) (including their full name and DOB) to request to be added to the medication wait list. The current estimated wait time is approximately 3 months from the date of request.

***Speech & Language / Occupational Therapy / Ed Psych***

1. Concerns were raised about (insert concern). It is recommended that this is discussed with the school or GP, who can consider whether any onwards referrals to other services may be necessary.

***Physical Health***

1. In view of (insert concern e.g. bladder problems), it is recommended that parent/carer discuss this further with their GP.

***Sleep***

1. Parent/carer reported difficulty with sleep. Getting a good night’s sleep is essential for both the child, and carers. We recommend that family explore the following online resources related to sleep hygiene. If difficulties persist, contact the GP.

* [Cerebra Sleep Advice Service](https://cerebra.org.uk/get-advice-support/sleep-advice-service)
* [Scope – Sleep Right Service](https://www.scope.org.uk/family-services/sleep-right)
* [National Autistic Society – Sleep Guidance](https://www.autism.org.uk/advice-and-guidance/topics/physical-health/sleep)
* [YouTube Video on Sleep Strategies](https://www.youtube.com/watch?v=fEyrB3lKjSk)

***Mental Health Support (High severity)***

1. It was reported that (insert concern). Given the level of need, a referral has been made to the local mental health team. In the meantime, if there are any concerns regarding risk or safety, it is important to contact the GP, NHS 111 or 999, depending on the level of urgency.

Clinician action: email [NDLS.AP@psicon.co.uk](mailto:NDLS.AP@psicon.co.uk) if you require support with processing a referral on your behalf

Please note, if you would like to amend any of the above further considerations, please contact the clinical lead BEFORE adding to report or advising family/client to check if this is available in the local area or in line with the local agreements.

**SUMMARY AND SIGN OFF**

It was a pleasure to meet with XXX and their family today. We sincerely hope that this assessment will help further the understanding of their individual needs and provide some guidance for the future.

Yours sincerely,

**Clinician Name**Job Title

ENC:

1. Appendix – Conners questionnaires
2. Appendix – QB check [if applicable]
3. Appendix – DSM-5 criteria
4. PDF – post-assessment support

**Appendix – Conners Questionnaires**

The **Conners Rating Scales** is a screening tool used to explore a young person’s attention, impulsivity, hyperactivity, and executive functioning across different environments. Completed by parents and teachers, it helps identify whether a full ADHD assessment is indicated and provides additional information to support the assessment process. While not diagnostic, the Conners offers valuable insights into the young person’s unique strengths and challenges in both home and school settings.

A T-score of 60–69 indicates elevated behaviours in that area compared to peers. A T-score of 70 and above suggests behaviours that are significantly different and often align with the ways in which individuals with ADHD experience and interact with the world. Scores above 70 are commonly observed in areas such as inattention, hyperactivity, and impulsivity for individuals with ADHD, providing valuable insights to guide further assessment and support.

XXX’s scores are presented below.

|  | **Parent/Carer** | **School** |
| --- | --- | --- |
| Inattention |  |  |
| Hyperactivity |  |  |
| Hyperactivity |  |  |
| Emotional Dysregulation |  |  |
| School Work |  |  |
| Peer Interactions |  |  |
| Family Life |  | - |

Whilst these questionnaires are important to help a clinician decide on the presence or absence of a diagnosis, the final conclusion is based on all information collected during the assessment process. The outcome may be different from what the Conners scores suggest. For example, it is not uncommon for scores between home and school to be different. Therefore the clinical expertise goes beyond the results to tease out features that may or may not be reflected on the scores of these quantitative measures.

There are many factors that influence how a child is rated at school and home, for example, a child’s motivation to do well in school, their ability to perform for shorter periods of time, how they may feel more supported/relaxed at home, anxiety levels and learning ability (to name a few). The clinician will interpret the results in light of the information they collect about the child’s overall functioning to reach a final conclusion regarding the presence of ADHD.

**Appendix – QB Check**

The **Quantified Behavioural Check (QB Check)** objectively measures the three core symptom domains of ADHD: hyperactivity, inattention and impulsivity, to provide quantitative assessment of a patient’s activity level, ability to pay attention and inhibit impulses. In addition to the QB Check, the patient performs an Ability Test that provides important information regarding their ability to manage the test situation.

A score above 1.0 identifies some difficulties and a score above 1.5 is clinically significant.

XXX’s scores are presented below.

|  | | Q-Score | Percentile |
| --- | --- | --- | --- |
| Hyperactivity | |  |  |
| Impulsivity | |  |  |
| Inattention | Omission errors |  |  |
| Reaction time |  |  |
| Reaction time variation |  |  |

Total ADHD symptom score: ###

**Appendix – DSM-5 Criteria for ADHD Diagnosis**

1. **A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterised by:**
2. **Inattention:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

* Fails to give close attention to details or makes careless mistakes
* Difficulty sustaining attention in tasks or play activities
* Does not seem to listen when spoken to directly
* Does not follow through on instructions and fails to finish tasks
* Difficulty organising tasks and activities
* Avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort
* Loses things necessary for tasks or activities
* Easily distracted by extraneous stimuli
* Forgetful in daily activities

1. **Hyperactivity and impulsivity:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

* Fidgets with or taps hands or feet or squirms in seat
* Leaves seat in situations when remaining seated is expected
* Runs about or climbs in situations where it is inappropriate (may be limited to restlessness in adolescents and adults)
* Unable to play or engage in leisure activities quietly
* Is often “on the go,” acting as if “driven by a motor”
* Talks excessively
* Blurts out an answer before a question has been completed
* Difficult waiting his or her turn
* Interrupts or intrudes on others

1. **Symptoms were present prior to age 12.**
2. **Several symptoms are present in two or more settings (e.g., home, school, work).**
3. **The difficulties interfere with, or reduce the quality of, social, academic, or occupational functioning.**
4. **The difficulties are not better explained by another mental disorder, such as anxiety, mood disorder, or personality disorder.**