UNIVERSITY OF CALIFORNIA, LOS ANGELES

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

UCLA

SANTA BARBARA • SANTA CRUZ

ADHD Clinic

Referral Screening Form

Thank you for referring your client to the UCLA CAPS ADHD Clinic.

The UCLA CAPS ADHD Clinic provides a focused evaluation for ADHD rather than a comprehensive psychological or neuropsychological assessment. Our evaluation typically includes:

- Clinical interview
- Adult ADHD Clinical Diagnostic Scale (ACDS)
- CAARS Self- and Observer Reports
- Conners Continuous Performance Test (CPT-3)

Because our evaluation is intentionally limited in scope, we rely on referring providers to supply clinical information regarding psychiatric, developmental, medical, and substance-related factors that may affect diagnostic clarification.

Completion of this questionnaire is required before an ADHD evaluation can be scheduled.

Each comment box provides space for a few sentences. If a response requires more room than the box allows, please continue it in the Additional Comments section at the end of this form, noting which item it refers to.

Please complete the following based on your clinical assessment. CAPS will use this information to determine whether the student's presentation is appropriate for a focused ADHD assessment or whether a more comprehensive evaluation is indicated.

Students may be deferred from the ADHD Clinic and referred for a comprehensive psychological or neuropsychological evaluation if there are significant concerns related to active psychosis, mania, unmanaged substance use, severe PTSD symptoms, acute safety concerns, or other factors that substantially limit diagnostic clarity.

Return This Form

Please return this completed form by either mail or fax — whichever is more convenient for your office:

Mail: UCLA Counseling and Psychological Services (CAPS), John Wooden Center West, 221 Westwood Plaza, Box 951556, Los Angeles, CA 90095-1556

Fax: (310) 206-7365

Questions or Concerns?

If you have any questions about this form or the referral process, please call the CAPS main line:

Phone: (310) 825-0768

REFERRING PROVIDER

Provider Name	**Credentials**
Practice / Agency	**Email**
Phone	**Student Name**
Length of Treatment	**Frequency of Sessions**

CURRENT CLINICAL INFORMATION

Current DSM-5-TR diagnoses (including provisional diagnoses):

Current psychiatric medications (include dosage if available):

Current clinical concerns other than ADHD for the clinic to consider:

CLINICAL HISTORY

Item	Yes	No	Unknown
Symptoms of inattention / executive functioning reportedly present prior to age 12	☐	☐	☐
Previous ADHD or neuropsychological assessment completed	☐	☐	☐

Comments (please explain any items marked Yes)

DIAGNOSTIC CLARIFICATION FACTORS

Substance Use

Substance	Past 3 Months	Historical Use	None	Unknown
Cannabis	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Nicotine	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Other	☐	☐	☐	☐

If Other, please specify:

Comments (For any item checked off, please indicate frequency and amount of use — e.g., two drinks, three times per week)

Sleep

Item	Response
Current sleep concerns	☐ None ☐ Insomnia ☐ Hypersomnia ☐ Irregular schedule ☐ Sleep apnea ☐ Other
Comments	

Eating

Item	Response
Current or history of eating concerns	☐ None ☐ Eating disorder ☐ Restrictive ☐ Binge eating ☐ Appetite disturbance ☐ Other
Comments	

Trauma

Item	Response
Current status	☐ None identified ☐ Trauma history ☐ PTSD diagnosis ☐ Current trauma-related symptoms
Comments	

PSYCHIATRIC HISTORY

Any item marked Unknown should be assessed prior to referral, or please contact CAPS to discuss before submitting this form.

Item	Yes	No	Unknown
Manic episode	☐	☐	☐
Hypomanic episode	☐	☐	☐
Psychotic symptoms	☐	☐	☐
Psychiatric hospitalization	☐	☐	☐

Comments (please explain any items marked Yes)

CURRENT RISK ASSESSMENT

Risk	Present	Not Present	Unknown
Active suicidal ideation	☐	☐	☐
Active homicidal ideation	☐	☐	☐
Active self-harm behaviors	☐	☐	☐
Current psychotic symptoms	☐	☐	☐
Current manic symptoms	☐	☐	☐
History of danger to self or others	☐	☐	☐

Comments (please explain any items marked Present)

RELEVANT DEVELOPMENTAL / MEDICAL HISTORY

History of head trauma? ☐ Yes ☐ No ☐ Unknown

History of seizures? ☐ Yes ☐ No ☐ Unknown

History of thyroid disorders? ☐ Yes ☐ No ☐ Unknown

Please describe any other relevant developmental or medical history:

ACADEMIC HISTORY

Please describe any relevant academic history:

CLINICAL RECOMMENDATION

Appropriate for focused ADHD evaluation? ☐ Yes ☐ No

If No, briefly explain:

Explanation

ADDITIONAL COMMENTS

Comments

PROVIDER ATTESTATION

I certify that the information provided above reflects my current clinical assessment of this student to the best of my knowledge.

Provider Signature	Date