

## ADHD Follow Up Appointment

Patient: \_\_\_\_\_ Grade: \_\_\_\_\_

Person completing form/relationship to patient: \_\_\_\_\_

Please list any changes in the patient's medical history since their last visit: \_\_\_\_\_

Please list any changes in the patient's family history since their last visit: (ex. Thyroid or heart problems, Tourette's, substance abuse) \_\_\_\_\_

Please list ALL CURRENT MEDICATIONS (NOT JUST ADD/ADHD medications): \_\_\_\_\_

How many days per week is the patient taking the medication? \_\_\_\_\_

How helpful is the medication?    Very helpful            somewhat helpful            unhelpful            makes things worse

Please circle the severity of the potential medication side effects that the patient is experiencing:

❖ Headache:	almost never	<1x/week	<2x/week	>2x/week	daily
❖ Stomach pain:	almost never	<1x/week	<2x/week	>2x/week	daily
❖ Decreased appetite:		none	mild	moderate	severe
❖ Sleep problems:		none	mild	moderate	severe
❖ Tremors/shaky feeling:		none	mild	moderate	severe
❖ Tics (repetitive movements):		none	mild	moderate	severe
❖ Picking at skin, nails, lips, etc.:		none	mild	moderate	severe
❖ Heart racing/skipping beats:		YES	NO		
❖ Irritability:		none	mild	moderate	severe
❖ Extremely sad or unusual crying:		none	mild	moderate	severe
❖ Socially withdrawn:		none	mild	moderate	severe
❖ Dull behavior/lacking enthusiasm:		none	mild	moderate	severe
❖ Concerns of medication abuse:		YES	NO		
❖ Prolonged or painful erections		YES	NO		

How have the patient's grades been compared to the last visit?    Same            better            still of concern

How is the patient's behavior at school compared to the last visit?    Same            better            still of concern

How is the patient's behavior at home compared to the last visit?    Same            better            still of concern

How is the patient's self esteem/attitude compared to the last visit?    Same            better            still of concern

Have there been any changes in the patient's life that you think are affecting the patient?    YES            NO

If yes, please comment here/reverse side.

# Lake Pointe Pediatric Associates, P.A.

6900 Scenic Drive Suite 103 Rowlett, Texas 75088 Telephone: 972-412-1034

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## SYMPTOM CHECKLIST FOR EVALUATION OF ATTENTION DEFICIT/HYPERACTIVITY DISORDER

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Person Completing Form: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

If teacher, what subject(s) and what time of day do you interact with the child? \_\_\_\_\_

Check the box that best describes this child compared with other children of the same gender and age.	Never	Sometimes	Often	Very Often
1. Fails to pay close attention to details/makes careless mistakes in work/tasks				
2. Has difficulty sustaining attention to task/chores/activities				
3. Does not seem to listen when spoken to directly				
4. Does not follow through on instructions and fails to finish work/chores (not due to oppositional behavior or failure to understand instructions)				
5. Has difficulty organizing task and activities				
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork)				
7. Loses things necessary for tasks or activities (eg. books/tools)				
8. Is easily distracted by unimportant stimuli (eg. noises)				
9. Is forgetful in daily activities				
10. Fidgets with hands or feet or squirms in seat				
11. Leaves seat when expected to remain seated				
12. Runs about or climbs excessively in inappropriate situations				
13. Has difficulty playing or engaging quietly in leisure activities				
14. Is "on the go" or often acts as if "driven by a motor"				
15. Talks excessively				
16. Blurts out answers before the questions have been completed				
17. Has difficulty awaiting turn				
18. Interrupts or intrudes on others' conversations/games/etc.				
19. Is uncooperative or defiant or argues with adults				
20. Has difficulty getting along with other children				
21. Is often angry, irritable, or easily upset				
22. Has excessive anxiety, worry, or fearfulness				
23. Seems sad, moody, depressed, or discouraged				
24. Has problems with academic progress (skill level or learning)				
25. Has problems with academic performance (productivity)				

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Child's Name: \_\_\_\_\_ DOB \_\_\_\_\_ Date: \_\_\_\_\_

We have compiled some information and suggestions to make the treatment of your child efficient and uninterrupted.

## Dear Parent:

Prior to your child's evaluation, we suggest you contact your health insurance to confirm coverage and benefits for Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder. We are providing you the International Classification of Diseases codes (ICD-9). For ADD the ICD-9 code is 314.00 and for ADHD the ICD-9 code is 314.01. We suggest you know which are the specific medications covered by your group plan. Here is a list of medications used to treat this syndrome: Adderall, Adderall XR, Concerta, Focalin, Focalin XR, Metadate CD, Ritalin, Ritalin LA and Strattera. If you change insurance provider, do not forget to re-confirm coverage. Some insurance plans exclude or have specific providers to treat patients with these disorders and will not pay for this treatment.

**Appointments:** If you need to schedule an ADD or ADHD recheck or follow up, please call 4 to 6 weeks prior to your needed appointment. Please keep in mind that your child will need to see the doctor *every six months* for as long as he/she is treated with medication/s.

**Refills:** We will not mail or fax controlled substance prescriptions. We require the parent or legal guardian signature on pick up. CONTROLLED SUBSTANCE prescriptions expire 21 days from the date signed. Your pharmacist WILL NOT process an expired prescription. Your doctor charges \$10.00 to reprocess an expired prescription. You must bring the expired prescription(s) back before a replacement prescription can be issued. The *Texas Department of Public Safety (DPS)* and *US Department of Justice, Drug Enforcement Administration (DEA)*, require for us to maintain a strict record of all controlled substance prescriptions.

## Helpful Numbers:

Appointment Desk: 972-412-1034 ext. 22

Prescription Refill Desk: 972-412-1034 ext. 25

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Patient Name: \_\_\_\_\_ Chart No. \_\_\_\_\_

I have received a copy of the **compiled information and suggestions** and understand Lake Pointe Pediatric Associates' policy regarding ADD prescriptions, insurance coverage and appointments.

\_\_\_\_\_  
Parent name

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

Keep in patient's chart