ADHD Care Plan

Patient Name: _____Nickname: _____DOB: ___/___/___
Parents/Guardians caring for child: _____Noncustodial parents: _____
Describe home environment and who lives in home: _____
Address: _____City:_____State:_____Zip: _____
Home phone:_____ Best time to reach: _____ E-mail: _____
Alternate phone 1: _____ Alternate phone 2:_____
Caregiver information: _____Other (describe): _____
Emergency Contact—Name: _____Phone: _____ Relationship: _____
Emergency Contact—Name: _____Phone: _____ Relationship: _____
Health Insurance/Plan: _____ Identification #: _____Group/Plan #:_____

Date: _____ Emergency Plan? Yes /No____ Complexity level: _____
☐ Created ☐ Maintained ☐ Updated

Primary Care Clinician: _____ Phone _____ Fax: _____ E-mail: _____
Medical Home Provider: _____ Phone _____ Fax: _____ E-mail: _____
(If applicable)
Contact/Coordinator: _____ Phone _____Fax: _____ E-mail: _____

DIAGNOSES/TREATMENT			
1. Primary Condition			
Diagnosis: **ADHD** Presentation/Subtype:		Date of Diagnosis:	
Symptoms/impairment/basis of diagnosis:			
Frequency:	Severity:	Time of Day:	
Treatment plan:			
Specialist/specialty	Clinic/hospital	Phone	Other contact info
2. Comorbid/Other Condition			
Diagnosis:		Date of Diagnosis:	
Notes:			
Treatment Plan:			
Specialist/specialty	Clinic/hospital	Phone	Other contact info
3. Comorbid/Other Condition			
Diagnosis:		Date of Diagnosis:	
Notes:			
Treatment Plan:			
Specialist/specialty	Clinic/hospital	Phone	Other contact info

Other comorbid conditions considered/reviewed/revisited (including substance use)	
Condition(s):	Date of Assessment(s):
Notes:	

Medications/supplements/vitamins	**Dosage**	**Schedule**

Allergies

Adverse reactions

Dietary modification recommendations

Recent diagnostic tests	**Results**

Therapies	
	Prescribed by: _____ ☐ Check if initiated by patient/family
	Prescribed by: _____ ☐ Check if initiated by patient/family

Recent clinical exam/results (since last visit)					**Date: ___/___/___**
Weight:	**Percentile:**	**Height:**	**Percentile:**	**BMI:**	**Percentile:**
Blood pressure:		**Pulse:**			
Other assessments, including checks for comorbidities:					

Hospitalizations (since last visit)

DEVELOPMENTAL/BEHAVIORAL

Problems/assessments	**Results**

PSYCHOSOCIAL

Patient/family concerns

Patient/family limitations to following treatment plan

School information	
Grade:	School attending/home school:
Counselor/Nurse:	Contact information:
Attendance regularity:	Academic performance/progress:
504, IEP (Include date updated):	Other:

CHILD DESCRIPTION

Child's assets and strengths

Extracurricular interests/recommendations

Challenges (Consider behavioral, communication, feeding and swallowing, hearing/vision, learning, orthopedic/musculoskeletal, physical anomalies, sensory, stamina fatigue, respiratory, other)

Equipment/appliances/assistive technology

Procedures/foods/activities/other to avoid

Prior surgeries/procedures and dates	
	___/__/__
	___/__/__
	___/__/__

Recent labs/diagnostic studies, results, and dates	
	___/__/__
	___/__/__
	___/__/__
	___/__/__

Other—Special circumstances/comments

EDUCATION PROVIDED

Educational materials provided at most recent visit Date: ___/___/___

TRANSITION PLAN

Transition plan status (Consider school transitions, healthcare transitions, etc) Date of discussion: ___/___/___

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ADHD Action Plan

Practice Name: _____ **Primary Contact:** _____

Address: _____ **Phone:** _____ **Fax:** _____

City: _____ **State** _____ **Zip:** _____

Practice Website URL/Patient Portal: _____

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

School: _____ Grade: _____ Contact: _____

As documented in your child's care plan, your child has a confirmed diagnosis of ADHD. Below are the actions discussed to help manage the ADHD symptoms.

Target Goals

In collaboration with the patient, family, school, and other major settings, establish 1–3 academic or social goals that are SMART (specific, measurable, attainable, realistic, and timely) AND consider the patient's motivation.

Goal	Who is Responsible?	Steps/Help Needed to Achieve?	By When?
1.			
2.			
3.			

DSM-based ADHD Rating Scales (Questionnaires)

Questionnaires completed by parents and teachers are a vital part of ADHD diagnosis and ongoing treatment. Information gathered by the questionnaires combined with feedback regarding behavioral changes and medication side effects informs about adjusting/maintaining the medication/dose according to the degree of improvement or impairment. We will provide copies of parent and teacher questionnaires today and require return of them periodically throughout the school year.

- ☐ Contact your child's teacher(s) to discuss plans for completion/return of questionnaires.
- ☐ **Next return date for parent/teacher forms:** __/__/__.

School

ADHD affects learning in many ways and may require classroom interventions to improve academic progress by lessoning deficiencies in areas such as attention, impulsivity, motor activity, organizational/planning skills, socialization, and academic skills.

- ☐ Work with the school to ensure that all medications, a copy of your child's health care plan, and current contact information are always with the supervising staff member, including on field trips.
- ☐ Work with the school on interventions to meet your child's learning style and improve academic progress.
- ☐ Work with the school to develop/update your child's 504 Plan or Individualized Education Program (IEP).
- ☐ Work with the school to establish/obtain Daily Home Report Card (DHRC) and progress reports.
- ☐ Work with the school to set/review target goals.

Treatment

- **Parent Training in Behavior Management:** Most children with ADHD benefit when families and caregivers learn behavior management techniques to help the child/adolescent control his/her behavior at home, school, and in social settings. Other behavioral and/or training interventions may also be beneficial.
  - ☐ Behavioral training/intervention recommended through evidence-based therapists/classes
    Name/Program: _____ Phone: _____
  - ☐ Daily Home Report Card (DHRC), a reward system for home and school
  - ☐ Organizational life skills/coaching _____
  - ☐ School counselor (Inquire if counselor can provide or has training in evidence-based behavioral health therapy.)
    Name: _____ Phone: _____
  - ☐ Specialty referral (ie, mental health professional) reason for referral: _____
    Name: _____ Phone: _____

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- **Medication:** Most school-age children/adolescents with ADHD benefit from treatment with medication. (Note: Medication is not the first-line treatment recommendation for preschool age-children.)

Medication Instructions				
At Home				
Name of Medication	**Dose**	**Frequency**	**Time of Day**	**Instructions (ie, take with food)**
In School				
Name of Medication	**Dose**	**Frequency**	**Time of Day**	**Instructions (ie, take with food)**

☐ Describe ADHD symptoms and impairment including frequency, severity, and time of day (used to compare symptoms after medication initiation/adjustment).

Symptoms/impairment:		
Frequency:	Severity:	Time of day:

☐ **Important: Notify our office if insurance does not cover the medication: Provide a list of medications they cover.**
☐ Ensure your child eats a good breakfast before taking medication, as medicine may decrease appetite later in the day.
☐ **Important: Call our office if your child is experiencing side effects such as persistent decrease in appetite, headache, nausea, and mood or personality changes.**

Additional Important Health Habits

☐ Good sleeping habits
☐ Healthy diet
☐ Regular exercise (One hour or more of daily activity)
☐ No substance use
☐ Other:

Contact, Follow-up Visits, and Medication Refills

For all follow-up visits, **bring Vanderbilt forms** and **notebook/binder** with school progress report, teacher comments, school assignment agenda, and DHRCs to each visit. Include information from other involved professionals/adults such as therapists, counselors, tutors, or coaches, as appropriate.

☐ Phone/electronic communication contact* and office follow-up visits are typically scheduled as follows:
- Contact made within 1–2 weeks of initiating ADHD medication and weekly until optimal dose is achieved.
- Follow-up visit within 30 days of initiating ADHD medication.
- Ongoing follow-up every __ months to review treatment plan, weight, height, blood pressure, and medication refills.
- Other: _____

☐ All ADHD medication refills require a mandatory office visit every __ months.
☐ All ADHD stimulant medications require regular check in by phone or electronic message every ___ month(s).
☐ **Next follow-up: ☐ Call: __/__/__ ☐ Visit: __/__/__**

ADHD Education/Resources

☐ _____
☐ _____
☐ _____
☐ _____

Additional Instructions

☐ _____
☐ _____
☐ Learn as much as you can about ADHD, network with other families, join a support group, advocate for your child.

This is a shared plan of care. By signing below, I indicate that I have reviewed and agreed upon the plan.

Patient/Family Signature: _____ **Date: ___/___/___**

Provider Signature:_____ **Date: ___/___/___**

*Use the Checklist of Medication Follow-up Questions to help guide phone contact

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Checklist of Medication Follow-Up Questions

☐ In-person, completed by parent: _____ ☐ By phone, completed by staff: _____	**Date: __ / __ / __**
1. Has your child started taking the medication prescribed?	☐ Yes ☐ No
If not, why?	
If yes, when did medication start?	
2. Please verify the ADHD medicine your child is currently taking. What is/are the medication name(s)?	
What is the dose?	
At what time is the medication taken and where is it administered?	Time: _____ ☐ Home ☐ School
How many tablets (or milliliters if liquid) of your child's ADHD medication are left?	
Do you need a refill of your child's ADHD medication?	☐ Yes ☐ No
3. Have you noticed any improvement toward your child's target goal(s)? If yes, what has improved?	☐ Yes ☐ No
4. Have you noticed any change in your child's ADHD symptoms? If yes, what has improved or worsened?	☐ Yes ☐ No
What time of the day do you notice a change in symptoms?	
What changes have been noticed in your child's behavior at home and at school?	
5. How has your child's performance at school changed (eg, homework completion, tests, progress reports)? Explain changes: _____ _____	☐ Yes ☐ No
6. Does your child have any side effects from the medication? Examples include headache, stomachache, change in appetite, trouble sleeping, irritability, socially withdrawn, extreme sadness or unusual behavior, tremors/feeling shaky, repetitive movements, picking at skin/fingers/nails, sees or hears things that aren't there, or other issues.	☐ Yes ☐ No Side effects:
7. What time of day does the medication stop working?	
8. What questions or concerns do you have?	

*Checklist of Medication Follow-up Questions

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