 **ADD-vance**

**The ADD-vance ADHD and Autism Trust**

**ADD-vance QbCheck Self-Referral Form (Child/YP)**

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| --- | --- | --- | --- | --- |
| Child/Young Person Name: | | Date of referral | | |
| Family Address: | | Contact number | | |
| Contact email | | |
| Home phone number | | |
| School/College: | | Mobile phone number | | |
| Preferred Contact number | | |
| School Address: | | Child DOB | | School Year |
| Parents’ Names: | | | | |
| Family Address: | | | | |
| Siblings names and DOB: | | | | |
| Diagnosis and any co-morbid diagnoses: | | | | |
| Medication: | | | | |
| Child protection issues: | | | | |
| Known family risk factors: **(We need to know of any risks within the family not just about the child)** | | | | |
| Any special requirements: | | | | |
| Other teams involved (past and present): | | | | |
| Reason for the test: | | | | |
| Source of funding: | | | | |
| Contact for invoicing purposes –  Name: | Address: | | Email: | |

Please return this form with any other relevant information to ADD-vance, preferably by email: [**adhdservice@add-vance.org**](mailto:adhdservice@add-vance.org)

Or post to:

**Jo Miller QbCheck Administrator**

**ADD-vance, Foundation House, 2-4 Forum Place, Fiddlebridge Lane**

**Hatfield, Hertfordshire AL10 0RN**

Enquiries please call: 01727 833963