 **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**

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