Precision North ADHD Clinic Inc.
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Precision North ADHD Assessment Referral Form

First Name: _____ Last Name: _____

Health No: _____ DOB: _____

Sex: ☐ M ☐ F ☐Other:_____ Email: _____

Phone: _____

ADHD Symptoms (select all that apply):

☐ Inattention to details / careless mistakes
☐ Not listening when spoken to directly
☐ Fails to follow instructions/finish tasks
☐ Engages in impulsive behaviors
☐ Hyperactivity
☐ Easily distracted
☐ Fidgeting/can't remain seated

Relevant Medical History:

Allergies: ☐ None ☐ Yes: _____

Fee Disclosure:

☐ I confirm the patient understands a private fee applies for assessment.

Referring Physician Information:

Physician Name: _____

Clinic Address:_____

Phone: _____

Fax: _____

Signature: _____