

**Attention Deficit Disorders Diagnosis Documentation Checklist for  
Treating Physician**

Please complete this form and return to the student. Please note that family members are not considered appropriate evaluators. **It is most important that you thoroughly explain any ADD/ADHD symptoms and indicate their impact on functioning.** If you wish to provide additional information, please attach it to the back of these forms. **The information you provide will *not* become part of the student's educational records.** Thank you.

Patient's name: \_\_\_\_\_ Patient's date of birth: \_\_\_\_\_

Date of most recent (**please circle one**) [evaluation/meeting with patient]: \_\_\_\_\_

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**I. If patient was diagnosed previously, please respond to the following:**

Patient previously diagnosed with (please circle one) [ADD / ADHD] in \_\_\_\_\_  
(year) when s/he was \_\_\_\_\_ (age) by \_\_\_\_\_  
(please print the name of physician)

Prior treatment (check all that apply):  
 pharmacotherapy  
 psychotherapy  
 other (please specify): \_\_\_\_\_

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**II. In order to (please circle one) [confirm prior diagnosis /diagnose] the presence of ADD/ADHD, I have:**

- A.  Conducted a semi structured diagnostic interview/consultation with the patient and gathered background information regarding ADD symptoms in the patient's:
1.  developmental history
  2.  academic history (elementary, high school, college)
  3.  psychosocial history
  4.  familial history (medical and psychiatric).
- B.  Conducted an assessment using the DSM-IV for ADD/ADHD

- C.  Administered and evaluated responses from ADD/ADHD rating scale(s)
- D.  Conducted assessments to rule out any medical conditions, mood, behavioral, neurological and personality disorders as the cause of the attentional and/or executive deficits.
- E.  Confirmed that ADD/ADHD symptoms have been present since childhood.
- F.  Confirmed impairment from symptoms of ADD/ADHD is present in (check all that apply):
- academic situations
  - work situations
  - social situations

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### **III. Diagnosis**

**Based on the above information, the student meets the most current DSM criteria for:**

- 314.00
  - Predominantly Inattentive
  - Predominantly Hyperactive Impulsive
- 314.01 Combined
- 314.9 Not otherwise specified

**OR**

- I **do not** believe that this student has an attention deficit disorder.

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### **IV. Comorbidity (please check all that apply):**

I have diagnosed the patient with the following comorbid condition(s):

- Depression
- Bi-polar
- OCD
- Anxiety Disorder
- Other: \_\_\_\_\_

- Patient previously diagnosed with a learning disability** (please attach the LD testing documentation.). Student has the following LD: \_\_\_\_\_

**I suspect the presence of a learning disability** and have suggested the patient pursue neurological/cognitive testing (if testing has been completed, please attach report)

**I do not suspect the presence of a learning disability**

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**V. ADD treatment and recommendations (please check only one option below)**

Patient is receiving pharmacotherapy and **his/her symptoms are no longer having a major impact on the patient's life**

**OR**

Patient **is** receiving pharmacotherapy and is experiencing a major impact on his/her life from the following symptoms :

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**OR**

Patient **is not** receiving pharmacotherapy and is experiencing a major impact on his/her life from the following symptoms:

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**(Please Print/Type the Name of Physician Completing this Form)**

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**Signature of Physician Completing this Form**

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**Date**