A Survey of the Management of ADHD in Primary Care

Please tick the appropriate box and add any comments as necessary.

1. How many children do you see personally with ADHD in your Practice, during the course of one year?

0-5 children ☐ 6-10 children ☐ More than 10 children ☐

2. Are you confident in recognising the symptoms of ADHD? Yes ☐ No ☐

Please comment: .....

.....

3. Which practitioner(s) do you refer to if you suspect ADHD in a child in your practice? *(tick all that apply)*

Child and Adolescent Psychiatrist ☐ Paediatrician ☐ CAMHS Service ☐

*Other ☐ *Please specify: .....

4. How would you rate the feedback you receive from the ADHD Clinic on the children referred?

Very good ☐ Good ☐ Not very good ☐ Poor ☐

Please comment: .....

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5. Do you feel that the reports and/or letters are timely? Yes ☐ No ☐

Please comment: .....

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6. Have you heard about the shared care guidelines for managing children with ADHD? *Yes ☐ No ☐

*If yes, do you use these guidelines within your practice? Yes ☐ No ☐

Please comment: .....

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7. Do you see any ADHD children for follow up? *Yes ☐ No ☐

*If yes, which of the following do you review regularly: *(tick all that apply)*

Height ☐ Weight ☐ Blood pressure ☐ Blood tests ☐

Please comment: .....

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8. Do you write repeat prescriptions for ADHD medications? ***Yes ☐ **No ☐

*If Yes, please tick which medications you write repeat prescriptions for:

- ☐ Short acting Methylphenidate
- ☐ Slow release Methylphenidate (Concerta XL, Equasym XL, Medikine XL)
- ☐ Dexamphetamine
- ☐ Clonidone
- ☐ Atomoxetine
- ☐ Psychotropic medications e.g. Risperidone
- ☐ Melatonin

Continued overleaf

**If No, please give reason: .....

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9. Are there any medications which you are unhappy to prescribe? *Yes ☐ No ☐

*If Yes, a) which are these medications:.....

b) would you like training on their use? Yes ☐ No ☐

10. How confident do you feel with writing repeat prescriptions?

Very confident ☐ Confident ☐ Fairly confident ☐ Not at all confident ☐ Not Applicable ☐

Please comment: .....

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11. Have you received any training on ADHD? ***Yes ☐ No ☐

*If yes, what form did the training take? (tick all that apply)

Informal lectures ☐ Clinical Training ☐ Conference ☐ DVD ☐ **Other ☐

**Please state:.....

12. Was the training of benefit to you? Yes ☐ No ☐ Not applicable ☐

Please comment: .....

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13. Would you be interested in further training on ADHD? *Yes ☐ No ☐

*If yes, how can we contact you with further information?

Email: ..... Telephone: .....

14. What suggestions do you have to help us improve the service?

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Name: …… **Practice:** …… **Date:** …… / …… / ……

Thank you for completing the questionnaire

Please return forms to your Practice Manager for return to us