Heilsugæsla höfuðborgarsvæðisins
Geðheilsuteymi HH-ADHD fullorðinna
Vegmúli 3, 108 Reykjavík
+(354) 513-6730

CLIENT APPLICATION FORM

REGARDING REFERRAL TO GEÐHEILSUTEYMI HH - ADHD FULLORÐINNA

If client has a prior diagnosis of ADHD during childhood a copy of the diagnostic report would be preferred to be sent along with the referral.

Informed consent form can be found on the last page.

Please answer the following questions as best as you can and make sure not to leave any questions unanswered. Remember that the information given will go into your medical record.

Date Name: Icelandic social security number/ identification number: Age: Telephone number: Email:

Work status

□ Working

□ Student

□ Receiving disability pension. If yes, why: _____

□ Unemployed

□ Other, what? _____

Marital status?
□ In a relationship, married or cohabitating
□ Single

Do you have children?
□ Yes, how many? _____
□ No

What is your living arrangement?

□ Own place

□ Rent

□ Social services apartment

□ Institution

□ Live with relative/friends

□ Other

Do you receive any kind of social services assistance?

□ Yes. What kind? _____

□ No

Have you ever received a diagnosis of attention deficit/hyperactivity (ADHD) during <u>childhood</u>? *The ADHD team does not accept or assess adult diagnosis reports from independent professionals.*

□ Yes, where from and which year? _____

□ No

Does anyone in your family have an ADHD diagnosis?

□ Yes. Who? _____

□ No

□ Don´t know

Does anyone in your family have a diagnosis of autism or Tourette's?

□ Yes, who? _____

□ No

□ Don´t know

Do you know if there were any problems during pregnancy or your birth?

□ Yes. Please explain _____

□ No

□ Don´t know

Did you have any childhood diseases?

□ Yes. Please explain_____

□ No

Did you start to walk and talk at a normal age

□ Yes

□ No. Please explain _____

□ Don´t know

Did your parents or teachers worry about your behaviour or development during preschool?

□ Yes. What did they worry about and at what age were you?

_____

□ No

Did your parents or teachers worry about your behaviour during elementary school?

□ Yes. What did they worry about? _____

□ No

Did you have problems sleeping as a child?

□ Yes. Please explain _____

□ No

Did you have trouble communicating with your peers as a child?

□ Yes. Please explain _____

□ No

What educational level have you finished?

□ Did not finish elementary school

□ Elementary school

□ Secondary school /Trade school

□ University

□ Other, what? _____

How were your grades in elementary school compared to your classmates?

□ Below average

□ Average

□ Above average

If secondary school, how were your grades then?

□ Below average

□ Average

□ Above average

How often have you started but not completed school? _____

Did you ever need special tutoring or special aid in your studies?

□ Yes. What kind? _____

□ No

Have you ever been diagnosed with dyslexia or any other learning disability?

□ Yes. What kind? _____

□ No

Please write your job history (what jobs and at what time)?

_____

_____

_____

_____

Have you ever experienced head trauma or lost consciousness due to a blow to the head?

□ Yes. How often? _____

□ No

Are there any known mental illnesses in your family?

□ Yes. Please explain: _____

□ No

□ Don´t know

Do you have any mental illnesses such as anxiety, depression or other?

□ Yes. Please explain _____

□ No

Have you ever sought help because of mental and/or behavioural problems?

□ Yes. Before the age of 18, please explain: _____

□ Yes. As an adult. Please explain: _____

□ No

Are you taking any medication because of mental problems?

□ Yes. Which medication? _____

□ No

Are you receiving other kind of treatment than medicinal because of mental problems?

□ Yes. What treatment? _____

□ No

Where have you sought help because of mental and/or behavioural problems?

□ I have not sought help

□ Landspítali, mental health unit

□ SÁÁ

□ BUGL (Landspítali, children and teen mental health unit)

□ Mental health unit at the hospital in Akureyri

□ Mental health unit at Reykjalundur

□ Mental health teams of health care (Heilsugæslu/Heilbrigðisstofnana)

□ Healthcare

□ Private practice Psychiatrist

□ Private practice Psychologist

□ Other private practice therapist

□ Other. Please explain: _____

Have you ever been arrested?

□ Yes. How often? _____

□ No

Have you ever been convicted of a crime?

□ Yes. What kind? _____

□ No

Have you ever served time in prison?

□ Yes. What for and how long? _____

□ No

Has consumption of alcohol or other intoxicants been a problem?

□ Yes. Please explain: _____

□ No

Have you ever had treatment for alcohol or substance addiction?

□ Yes. Please explain: _____

□ No

How often do you consume alcohol?

□ Never

□ Never in the last year

□ Never in the last six months

□ Less than once a month

□ Once a month

□ A few times every month

□ Weekly

□ A few times a week

□ Daily

How often do you use substances?

□ Never

□ Never in the last year

□ Never in the last six months

□ Less than once a month

□ Once a month

□ A few times every month

□ Weekly

□ A few times a week

□ Daily

Do you use nicotine?

□ Yes. How many cigarettes a day approximately? _____

□ Yes, vape. How much a day approximately? _____

□ Yes, nicotine pouches, How many a day approximately? _____

□ Yes. However, I am trying to quit

□ No. Used to before

□ No. Never smoked

INFORMED CONSENT

The undersigned do hereby consent that this referral is to be sent to the Mental Health Team Adult ADHD of the Primary Health Care of the Capital Area (HH) alongside relevant medical records/data that I provided from my health care providers outside of Iceland. I confirm with my signature that permission is granted that health care providers working within the team are permitted to obtain, review and utilize information/data from my medical records that is relevant to the teams services. The utmost confidentiality is maintained regarding the processing of aforementioned information. Personal information and its registration will be handled in accordance with Act No. 121/1989 of the Icelandic law. This consent can be withdrawn alongside the application for the team's services.

Name: _____

Icelandic SSN (Kennitala): _____

Signature:

_____