# ADHD Care Management Plan

**Physician:** _____
□ Primary Evaluation
□ Referred for Evaluation
□ Referred from Specialist
□ Re-evaluation

Date: _____ Patient Name: _____ DOB: _____ Parent/Guardian Names: _____

**Goals - Behavior Targeted for Improvement**

□ Improved "on-task" behavior
□ Gets self ready for school in the morning
□ Efficiently completes and returns homework
□ Willingly completes homework
□ Bringing homework assignments home
□ Other_____
□ Other_____
□ Less impulsive (thinks before acting, speaking etc)
□ Only has to be asked once to complete tasks or activities
□ Improved relationships with parents, siblings, peers, etc
□ Getting into less trouble at school
□ Improvement of grades and school performance

Date of Achieved Goal(s):

**Plans to Meet These Goals**

☐ Medication Started: Yes ___ No ___ If yes, list **date**: _____
List Medication/Dosage: _____
☐ Behavior Therapy Referral: Yes _____ No _____
☐ Other Intervention(s): _____
☐ Handouts given, including websites, list of school and community resources
☐ Copy of ADHD Care management plan faxed, sent, or hand-delivered to school/teacher
☐ Referral for further evaluation:

**Date of 7 - 14-Day Phone Follow-Up: _____**
- Result of Phone Follow-Up (circle one): **A.** Continue current dose **B.** Change dose: Increase to _____ Decrease to _____ **C.** Change medication: _____

**Date of 4 – 6 Week Office Follow-Up:** Scheduled Appt Date**: _____**
Actual Appt Date: _____

**List Initial Vanderbilt scores, Follow-Up Contact, and Follow-Up Vanderbilt scores below:**

**KEY**: **T**=Telephone, **O**=Office, **I** = Inattention, **HA** = Hyperactivity, **TSS =** Total Symptom Score for Inattention and Hyperactivity

| Date | Name | Follow Up | | Parent Vanderbilt | | | | | | | | | | | | | | | Teacher Vanderbilt | | | | | | | | | | | | | | Treatment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | IMPAIRMENT Check only if a 4 or 5 is circled in the impairment section A - H | | | | | | | | | | | | | | | IMPAIRMENT Check only if a 4 or 5 is circled in the impairment section A – H | | | | | | | | |
| | | T | O | I 1-9 | HA 10 -18 | TSS 1-18 | ODD 19-26 | CD 27-40 | A/D 41-47 | A. School | B. Reading | C. Writing | D. Math | E. Parents | F. Siblings | G. Peers | H. Activities | Name | I 1-9 | HA 10 - 18 | TSS 1-18 | ODD/ CD 19-28 | A/D 29-35 | A. Reading | B. Math | C. Writing | D. Peers | E. Directions | F. Disrupting Class | G. Completes Assign. | H. Organization | Medication Dosage |
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**Please sign to verify agreement with the Written Care Management Plan:**

_____ Physician _____ Date _____ Parent/Guardian _____ Date _____ Patient _____ Date