

ADHD Care Management Plan

Date: _____ Patient Name: _____ DOB: _____

Parent/Guardian Names: _____

Physician: _____

- Primary Evaluation
- Referred for Evaluation
- Referred from Specialist
- Re-evaluation

Goals - Behavior Targeted for Improvement	Date Goal(s) Achieved	Plans to Meet These Goals
<input type="checkbox"/> Improved "on-task" behavior <input type="checkbox"/> Less impulsive (thinks before acting, speaking etc) <input type="checkbox"/> Gets self ready for school in the morning <input type="checkbox"/> Only has to be asked once to complete tasks or activities <input type="checkbox"/> Efficiently completes and returns homework <input type="checkbox"/> Improved relationships with parents, siblings, peers, etc <input type="checkbox"/> Willingly completes homework <input type="checkbox"/> Getting into less trouble at school <input type="checkbox"/> Bringing homework assignments home <input type="checkbox"/> Improvement of grades and school performance <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____	<input type="checkbox"/> Medication Started: Yes ___ No ___ If yes, list date : _____ List Medication/Dosage: _____ <input type="checkbox"/> Behavior Therapy Referral: Yes _____ No _____ <input type="checkbox"/> Other Intervention(s): _____ <input type="checkbox"/> Handouts given, including websites, list of school and community resources <input type="checkbox"/> Copy of ADHD Care management plan faxed, sent, or hand-delivered to school/teacher <input type="checkbox"/> Referral for further evaluation:

Phone Follow-Up

Date of 7 – 14 day follow-up: Scheduled Date: _____ Actual Date: _____

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

- Additional Comments: _____

Date of 14 – 21 day follow-up (optional): Scheduled Date: _____ Actual Date: _____

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

- Additional Comments: _____

Office Follow-Up

Date of 4 – 6 Week: Scheduled Appt Date: _____ Actual Appt Date: _____

- Additional Comments: _____
