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Dear Colleague:

Attention-deficit/hyperactivity disorder (ADHD) is challenging for children, families, schools, and clinicians. The American Academy of Pediatrics (AAP) has developed this toolkit to assist clinicians in providing quality care for children with ADHD. An unrestricted educational grant to support the development, production, and dissemination of this toolkit was provided by McNeil Consumer and Specialty Pharmaceuticals.

Rooted in the evidence-based AAP guidelines for the diagnosis and treatment of children with ADHD, this toolkit provides excellent resources for clinicians. These tools can provide the basis for a coordinated, integrated, and multidisciplinary system of care. We hope to encourage collaboration among primary care professionals, school personnel, parents, and children.

Using initial development funds from the Centers for Education and Research on Therapeutics (CERTs) at the University of North Carolina, funded by the Agency for Healthcare Research and Quality (federal grant 5 U18 HS10397—"Rational Therapeutics for the Pediatric Population"), the National Initiative for Children's Healthcare Quality (NICHQ) worked with experts to identify and catalog resources to assist clinicians who care for children with ADHD. The 75 tools initially collected included those in the public domain and those contributed by clinical and educational specialists. NICHQ worked with the AAP ADHD Guidelines Implementation Project Advisory Committee to cull the library of tools to a manageable number that could be tested and adapted more easily. The 30 primary care practices participating in NICHQ's Learning Collaborative, Improving Care for Children with ADHD, used and modified the tools; 4 of these practices, from the AAP Pediatric Research in Office Settings (PROS) network, worked closely with NICHQ staff to give specific feedback and suggestions for improvement (Panorama Pediatrics Group, Rochester, NY; St Johnsbury Pediatrics, St Johnsbury, VT; Children's Hospital of Michigan, Detroit; and Nemours and Orlando Regional Healthcare Pediatric Outpatient Department, Orlando, FL). Finally, Harlan Gephart, MD, and Laurel Leslie, MD, reviewed the revised tools, ensuring that they are accurate and user-friendly.

Additional forms can be downloaded from the AAP Members Only Channel on the AAP Web site (www.aap.org/moc). The AAP online program, Education for Quality Improvement for Pediatric Practice (eQIPP), will have a module on ADHD available in spring 2003 that will provide downloadable tools and interactive case scenarios. The AAP is committed to exploring opportunities to update the toolkit to ensure users have the most current and timely resources available.

We hope this toolkit will serve as a valuable resource in your practice.

Joe M. Sanders, Jr, MD
Executive Director
American Academy of Pediatrics

INTRODUCTION

Attention-deficit/hyperactivity disorder (ADHD) is one of the most common chronic childhood disorders. Current estimates indicate that 4% to 12% of all school-aged children may be affected. ADHD is a neurobehavioral disorder that usually appears in children before the age of 7.

Children with ADHD may have difficulty controlling their behavior in school and social settings and often fail to achieve their full academic potential. Clinically, the child may present with varying symptoms of hyperactivity, impulsivity, and/or inattention. The child may be easily distracted, be unable to pay attention and follow directions, be overactive, and/or have poor self-control.

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, characterizes the following 3 subtypes of ADHD:

- Inattentive only (ADHD-IA) (formerly known as attention-deficit disorder [ADD])—Children with this form of ADHD are not overly active. Because they do not disrupt the classroom or other activities, their symptoms may not be noticed. Among girls with ADHD, this form is most common. Approximately 30% to 40% of children with ADHD have this subtype.
- Hyperactive/Impulsive (ADHD-H/I)—Children with this type of ADHD show hyperactive and impulsive behavior but can pay attention. This subtype accounts for a small percentage, approximately 10%, of children with ADHD.
- Combined Inattentive/Hyperactive/Impulsive—Children with this type of ADHD show all 3 symptoms. This is the most common type of ADHD. The majority of children with ADHD have this subtype, approximately 50% to 60%.

The diagnosis of ADHD relies on the documentation of symptoms that are associated with functional impairment from multiple environments. Because of this, school personnel, families, and primary care clinicians need to work collaboratively to document specific symptoms and their effect on a child's functioning. School personnel and families also need to be aware that there currently are no biological markers or computerized tests that allow for diagnostic specificity.

Once a diagnosis of ADHD has been made with confidence, the primary care clinician can approach the issue of treatment of the child with ADHD. This involves developing a management plan that incorporates the appropriate medication and/or behavior therapy to meet target outcomes. The care of most children with ADHD can be managed in a primary care setting.

The role of the primary care clinician is to

- Synthesize and interpret information about a child's behavior.
- Identify other medical or psychosocial problems that might be causing and/or exacerbating the child's symptoms.
- Refer for further evaluation where needed.
- Arrange other treatment (eg, educational, psychological) as needed.
- Provide appropriate medical treatment.
- Monitor progress.
- Support parents in their role as advocates for the child.

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DIAGNOSIS

Diagnosis and Evaluation of the Child With Attention-Deficit/Hyperactivity Disorder

An effective treatment begins with an accurate, well-established diagnosis.

This AAP clinical practice guideline contains the following recommendations for diagnosis of ADHD:

1. In a child 6 to 12 years old who presents with inattention, hyperactivity, impulsivity, academic underachievement, or behavior problems, primary care clinicians should initiate an evaluation for ADHD.
2. The diagnosis of ADHD requires that a child meet *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV),* criteria.
3. The assessment of ADHD requires evidence directly obtained from parents or caregivers regarding the core symptoms of ADHD in various settings, the age of onset, duration of symptoms, and degree of functional impairment.
4. The assessment of ADHD requires evidence directly obtained from the classroom teacher (or other school professional) regarding the core symptoms of ADHD, duration of symptoms, degree of functional impairment, and coexisting conditions.
5. Evaluation of the child with ADHD should include assessment for associated (coexisting) conditions.
6. Other diagnostic tests are not routinely indicated to establish the diagnosis of ADHD but may be used for the assessment of other coexisting conditions (eg, learning disabilities, mental retardation).

This clinical practice guideline is not intended as a sole source in the evaluation of children with ADHD. Rather, it is designed to assist primary care clinicians by providing a framework for diagnostic decision making. It is not intended to replace clinical judgment or to establish a protocol for all children with the condition.

Tools

NICHQ ADHD Primary Care Initial Evaluation Form

Intended for use by the clinician, this tool helps organize the various pieces of information needed to make a diagnosis of ADHD: patient history; pertinent physical examination including vision, hearing, and neurologic screening; and data from the assessment scales (described below). This form also can serve to ensure the child has received a treatment plan, appropriate referrals, and a follow-up appointment. *This sample is provided as a template; a clinician can adapt this tool to fit his or her own practice and approach.*

The NICHQ Vanderbilt Parent and Teacher Assessment Scales

NICHQ Vanderbilt Assessment Scale—PARENT Informant

NICHQ Vanderbilt Assessment Scale—TEACHER Informant

NICHQ Vanderbilt Assessment Follow-up—PARENT Informant

NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant

Scoring Instructions for the NICHQ Vanderbilt Assessment Scales

SAMPLE NICHQ Vanderbilt Assessment Scale—PARENT Informant

A child must meet *DSM-IV* criteria for a diagnosis of ADHD to be appropriate. To confirm a diagnosis of ADHD, these behaviors must

- Occur in more than one setting, such as home, school, and social situations
- Occur to a greater degree than in other children the same age
- Begin onset before the child reaches 7 years of age and continue on a regular basis for more than 6 months
- Significantly impair the child's academic and social functioning
- Not be better accounted for by another disorder

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DIAGNOSIS, CONTINUED

Many school-aged children have some of these symptoms, either transiently or in a mild form, and it is important to establish the high frequency of symptoms to make the diagnosis of ADHD. The NICHQ Vanderbilt Parent and Teacher Assessment Scales are one way to do this. The NICHQ Vanderbilt Assessment Scales also screen for the following coexisting conditions: oppositional-defiant disorder, conduct disorder, and anxiety and depression. If a screen is positive, a more detailed evaluation is warranted. It also should be noted that the scales will not pick up learning disabilities, suicidal behaviors, bipolar disorder, alcohol and drug use, or tics—all of which may be present in a child with ADHD.

The NICHQ Vanderbilt Assessment Follow-up tools help assess the treatment's effectiveness. There are forms for use by the parent and teacher. Intended for use by the clinician and staff, the scoring instructions provide a set of directions for scoring the NICHQ Vanderbilt Assessment and Follow-up Scales.

Cover Letter to Teachers

This serves as a means of communication and an introductory letter that may accompany the assessment scales that you request from the school. It is suggested that a "release of information" form, signed by the parent, accompany the letter. This sample is provided as a template; a clinician can adapt this tool to fit his or her own practice and approach.

The NICHQ Vanderbilt Parent Assessment Scale

How to score the parent checklist

The NICHQ Vanderbilt scale is divided into 2 sections: Symptoms and Performance. When handing the assessment scale to the parent, point out how to fill out the form correctly.

- The Symptoms section identifies the frequency of occurrence. Direct the parent to circle only 1 of the 4 numbers on the scale.
- The Performance section indicates the level of impairment. Direct the parent to circle only 1 of the 5 numbers on the scale.

Once the form is completed, the ADHD subtype can be determined.

a. For questions 1–9, add up the number of questions where the parent circled a 2 or 3.

b. For questions 10–18, add up the number of questions where the parent circled a 2 or 3.

c. For questions 48–55, add up the number of questions where the parent circled a 4 or 5.

- For Predominantly Inattentive subtype, at least 6 of questions 1–9 must score a 2 or 3. In addition, at least 1 of questions 48–55 must score a 4 or 5.
- For Predominantly Hyperactive/Impulsive subtype, at least 6 of questions 10–18 must score a 2 or 3. In addition, at least 1 of questions 48–55 must score a 4 or 5.
- For Combined Inattention/Hyperactivity subtype, at least 6 of questions 1–9 and 6 of questions 10–18 must score a 2 or 3. Additionally, at least 1 of questions 48–55 must score a 4 or 5.

What to tell the parent while you are scoring

You can walk a parent through what you are doing. This is helpful in educating them about their child's condition.

Note: Alternately, staff can score the rating scale. The parent can turn the scale in to the front desk, and a nurse or administrative assistant can score it and attach it to the patient's file. Some clinicians also use questionnaires to collect the history as well as *DSM-IV* criteria and score this packet prior to seeing the child and family. This may allow for a more efficient use of time in the office.

DIAGNOSIS, CONTINUED

The NICHQ Vanderbilt Teacher Assessment Scale

Teachers often are the first to notice behavior signs of possible ADHD. Children 6 to 12 years of age spend many of their waking hours at school, and the teacher is a powerful source of information about the child's behaviors, interactions, and academic performance. To make an accurate diagnosis, information about the child will be needed directly from the child's classroom teacher or another school professional. The child's academic and classroom behavior is necessary to corroborate the diagnosis and identify potential learning disabilities.

The guideline specifies that this information can be obtained using narratives from the teacher or specific rating scales. Some clinicians find it helpful to do both.

In addition to using an ADHD rating scale, many clinicians find it helpful to talk directly with the teacher to obtain richness beyond the rating scales. For example, ask the teacher to describe

- The child's behavior in the classroom
- The child's learning patterns
- How long the symptoms have been present
- How the symptoms affect the child's progress at school
- Ways the teacher has adapted the classroom program to help the child
- Whether other conditions contribute to or affect the symptoms

In addition, ask to see report cards and samples of the child's schoolwork, as well as any formal testing performed by school personnel.

This interview can take place over the phone or in the form of a written narrative or a paper or computer-based questionnaire.

How to score the teacher checklist

The ADHD-specific questionnaires and rating scales also are available for teachers. These scales accurately distinguish between children with and without the diagnosis of ADHD. Whether these scales provide additional benefit beyond narratives or descriptive interviews informed by *DSM-IV* criteria is not known. Using scales can give an objective rating for monitoring improvements.

A corresponding teacher scale to complement the parent questionnaire has been developed. Once the form is completed, the ADHD subtype can be determined.

a. For questions 1–9, add up the number of questions where the teacher circled a 2 or 3.

b. For questions 10–18, add up the number of questions where the teacher circled a 2 or 3.

c. For questions 36–43, add up the number of questions where the teacher circled a 4 or 5.

- For Predominantly Inattentive subtype, at least 6 of questions 1–9 must score a 2 or 3. In addition, at least 1 of questions 36–43 must score a 4 or 5.
- For Predominantly Hyperactive/Impulsive subtype, at least 6 of questions 10–18 must score a 2 or 3. In addition, at least 1 of questions 36–43 must score a 4 or 5.
- For Combined Inattention/Hyperactivity subtype, at least 6 of questions 1–9 and 6 of questions 10–18 must score a 2 or 3. In addition, at least 1 of questions 36–43 must score a 4 or 5.

TREATMENT

A treatment plan is tailored to the individual needs of the child and family. It may require medical, educational, behavioral, and psychological interventions. This multimodal approach can improve the child's behavior in the home, classroom, and social settings. In most cases, successful treatment will include a combination of stimulant medication and behavior therapy.

The AAP clinical practice guideline, "Treatment of the School-Aged Child With Attention-Deficit/Hyperactivity Disorder," contains the following recommendations for treatment of ADHD in children aged 6 to 12 years:

1. Primary care clinicians should establish a treatment program that recognizes ADHD as a chronic condition.
2. The treating clinician, parents, and the child, in collaboration with school personnel, should specify appropriate target outcomes to guide management.
3. The clinician should recommend stimulant medication and/or behavioral therapy as appropriate to improve target outcomes in children with ADHD.
4. When the selected management for a child with ADHD has not met target outcomes, clinicians should evaluate the original diagnosis, use of all appropriate treatments, adherence to the treatment plan, and presence of coexisting conditions.
5. The clinician should periodically provide a systematic follow-up for the child with ADHD. Monitoring should be directed to target outcomes and adverse effects by obtaining specific information from parents, teachers, and the child.

The AAP guideline recognizes the variation in severity and complexity of children presenting with ADHD and specifically limits the target population to children aged 6 to 12 years with ADHD but without major coexisting conditions.

Tools

ADHD Management Plan (2 Samples)

The ADHD Management Plan is a written handout for the child and family describing planned goals, indicating when and how to take any prescribed medications, and outlining the next steps. Its purpose is to help the child and family manage his or her ADHD.

The monitoring plan should consider normal developmental changes in behavior over time, educational expectations that increase with each grade, and the dynamic nature of a child's home and school environment. Changes in any of these areas may alter target behaviors.

This form also can be used to monitor the date of refills, medication type, dosage, frequency, quantity, and responses to treatment (both medication and behavior therapy).

These samples are provided as a template; a clinician can adapt either version to fit his or her own practice and approach.

How to Establish a School-Home Daily Report Card

The Daily Report Card (DRC) is a form of behavior modification that can be used to reward the child for meeting specific target outcomes in home and classroom settings.

This tool follows the same concept as an academic report card, but focuses on the child's behaviors. The DRC provides immediate feedback on the child's behaviors. Each day, the parent fills out a DRC on the child's behavior at home. Similarly, the teacher fills out the DRC on the child's behavior at school and sends it home. The parent rewards the child for a good report, or withholds a privilege in the case of a bad report.

The physician will need to be familiar with these tools to assist with the implementation of the DRC by reviewing it with parents; this provides parents with the direction needed to use this tool at home and assist the teacher with its use at school. This tool provides for communication among the school, parents, and clinician so all parties involved in the child's care know how well the child is meeting his or her target outcomes.

Stimulant Medication Management Information

Intended for use by the clinician, this tool reviews the types of stimulants available, dosing, and potential side effects. This chart will need updating at intervals as new medications are introduced.

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PARENT INFORMATION AND SUPPORT

The AAP ADHD clinical practice guidelines underscore the important role of children and families in the evaluation process as well as the design of an appropriate management plan. The following tools can facilitate the inclusion of the child and family:

Tools

Understanding ADHD: Information for Parents About Attention-Deficit/Hyperactivity Disorder
This excellent AAP booklet provides answers to many of parents' most common questions about ADHD.

Does My Child Have ADHD?
This tool suggests parents monitor some of their child's behaviors to facilitate the evaluation for ADHD.

Evaluating Your Child for ADHD and ADHD Evaluation Timeline
This tool includes a timeline that can help parents or caregivers understand the steps required for making a diagnosis and facilitate obtaining the necessary information.

For Parents of Children With ADHD
This list contains helpful suggestions on parenting a child with ADHD.

What Can I Do When My Child Has Problems With Sleep?
This is a handout for parents with suggestions for how to handle children with ADHD who have problems with sleep.

Educational Rights for Children With ADHD
Intended primarily for use by the clinician, this tool can be used to guide parents' decisions about educational interventions to help children with ADHD.

Homework Tips for Parents
This list contains helpful suggestions on completing educational assignments.

Working With Your Child's School
This is a parent education piece that provides suggestions for initiating an educational partnership, collaborating on the child's evaluation, and cooperating throughout the child's school career on the targeted outcomes.

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RESOURCES

Tools

ADHD Coding Fact Sheet for Primary Care Clinicians
This tool summarizes helpful facts to ensure appropriate coding for ADHD services.

ADHD Encounter Form
This is a sample billing form that a clinician can adapt for his or her practice and approach.

Documentation for Reimbursement
This is a sample letter that a clinician can use to document the provision of ADHD care for insurance purposes. A clinician can adapt this for his or her practice and approach.

ADHD Resources Available on the Internet
This is a list of Web sites of organizations and resources helpful to the family, clinician, and school.

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NICHQ ADHD Primary Care Initial Evaluation Form

Patient Name _____ Date of Birth _____ Date of Evaluation _____

Info From: ☐ Parent(s) _____ ☐ Patient ☐ Teacher ☐ Current School/Grade _____

Teacher Name(s) _____ Phone #(s) _____

Counselor Name(s) _____ Phone #(s) _____

Significant Past Medical History

☐ Birth history _____ ☐ Developmental/behavioral history _____

☐ Health history _____ ☐ Family medical history _____

☐ Current medications _____ ☐ Prior ADHD diagnosis and/or treatment _____

☐ Stressors _____

Physical Examination

Height _____ Weight _____ BP _____

HEENT/NECK: CHEST/COR/LUNGS:

ABD: GU:

NEURO:

LAB/EVALUATIONS: ☐ Vision _____ ☐ Hearing _____

NOTES:

Chief Concerns

ADHD Diagnostic Assessment: Rating scale used? ☐ Yes ☐ No If yes, scale used: ☐ NICHQ Vanderbilt ☐ Other

ADHD Subtype Score, Impairment, and Performance: *Parent Report*	Total Number of Positive Symptoms	Criteria	Meets *DSM-IV* Criteria?
Inattentive (questions 1–9); scores of 2 or 3 are positive.	/9	6/9 + 1 positive impairment score	☐ Y ☐ N
Hyperactive (questions 10–18); scores of 2 or 3 are positive.	/9	6/9 + 1 positive impairment score	☐ Y ☐ N
Combined (questions 1–18); scores of 2 or 3 are positive.	/18	12/18 + 1 positive impairment score	☐ Y ☐ N
Performance (questions 48–55); scores of 4 or 5 are positive.	/8		

ADHD Subtype Score, Impairment, and Performance: *Teacher Report*	Total Number of Positive Symptoms	Criteria	Meets *DSM-IV* Criteria?
Inattentive (questions 1–9); scores of 2 or 3 are positive.	/9	6/9 + 1 positive impairment score	☐ Y ☐ N
Hyperactive (questions 10–18); scores of 2 or 3 are positive.	/9	6/9 + 1 positive impairment score	☐ Y ☐ N
Combined (questions 1–18); scores of 2 or 3 are positive.	/18	12/18 + 1 positive impairment score	☐ Y ☐ N
Performance (questions 36–43); scores of 4 or 5 are positive.	/8		

Symptoms present >6 months?	☐ Y ☐ N
Symptoms present to some degree <7 years old?	☐ Y ☐ N

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NICHQ ADHD Primary Care Initial Evaluation Form

Screening for Co-morbidities

From Parent NICHQ Vanderbilt:

- ☐ **Oppositional-Defiant Disorder** is screened by 4 of 8 symptoms (scores of 2 or 3 are positive) (questions 19 through 26) AND a score of 4 or 5 on any of the 8 Performance Section items.
- ☐ **Conduct Disorder** is screened by 3 of 14 symptoms (scores of 2 or 3 are positive) (questions 27 through 40) AND a score of 4 or 5 on any of the 8 Performance Section items.
- ☐ **Anxiety/Depression** are screened by 3 of 7 symptoms (scores of 2 or 3 are positive) (questions 41 through 47) AND a score of 4 or 5 on any of the 8 Performance Section items.

From Teacher NICHQ Vanderbilt: Scores of 2 or 3 on a single item reflect ***often-occurring*** behaviors.

- ☐ **Oppositional-Defiant/Conduct Disorder** are screened by 3 of 10 items (scores of 2 or 3 are positive) (questions 19 through 28) AND a score of 4 or 5 on any of the 8 Performance Section items.
- ☐ **Anxiety/Depression** are screened by 3 of 7 items (scores of 2 or 3 are positive) (questions 29 through 35) AND a score of 4 or 5 on any of the 8 Performance Section items.

From Other Sources:

☐ Mental health problems _____ ☐ Learning disabilities _____

☐ Other medical conditions _____

Assessment

- ☐ **Does not meet criteria for ADHD.**
- ☐ **Predominantly Inattentive subtype** requires 6 out of 9 symptoms (scores of 2 or 3 are positive) on items 1 through 9 AND a performance problem (scores of 4 or 5) in any of the items on the Performance Section for both the Parent and Teacher Assessment Scales.
- ☐ **Predominantly Hyperactive/Impulsive subtype** requires 6 out of 9 symptoms (scores of 2 or 3 are positive) on items 10 through 18 AND a performance problem (scores of 4 or 5) in any of the items on the Performance Section for both the Parent and Teacher Assessment Scales.
- ☐ **ADHD Combined Inattention/Hyperactivity** requires the above criteria on both Inattentive and Hyperactive/Impulsive subtypes.
- ☐ **ADHD not otherwise specified.**

Plan

☐ Patient provided with a written ADHD Management Plan

Management _____

Medication _____

Titration follow-up plan _____

Behavioral counseling _____

School _____

Other specialist referral _____

Follow-up office visit scheduled for _____

Goal for measurement at follow-up (specific criteria, eg, homework done, decrease school disciplinary notes)

_____

_____

_____

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NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

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D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

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D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (eg, teams)	1	2	3	4	5

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

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HE0352

D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant, continued

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?**			
	None	**Mild**	**Moderate**	**Severe**
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score for questions 19–26: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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11-21/rev0303

D6 NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the last assessment scale was filled out. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Reading	1	2	3	4	5
20. Mathematics	1	2	3	4	5
21. Written expression	1	2	3	4	5
22. Relationship with peers	1	2	3	4	5
23. Following direction	1	2	3	4	5
24. Disrupting class	1	2	3	4	5
25. Assignment completion	1	2	3	4	5
26. Organizational skills	1	2	3	4	5

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

D6 NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant, continued

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Side Effects: Has the child experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?**			
	None	**Mild**	**Moderate**	**Severe**
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score: _____

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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Scoring Instructions for the NICHQ Vanderbilt Assessment Scales

These scales should NOT be used alone to make any diagnosis. You must take into consideration information from multiple sources. Scores of 2 or 3 on a single Symptom question reflect *often-occurring* behaviors. Scores of 4 or 5 on Performance questions reflect problems in performance.

The initial assessment scales, parent and teacher, have 2 components: symptom assessment and impairment in performance. On both the parent and teacher initial scales, the symptom assessment screens for symptoms that meet criteria for both inattentive (items 1–9) and hyperactive ADHD (items 10–18).

To meet *DSM-IV* criteria for the diagnosis, one must have at least 6 positive responses to either the inattentive 9 or hyperactive 9 core symptoms, or both. A positive response is a 2 or 3 (often, very often) (you could draw a line straight down the page and count the positive answers in each subsegment). There is a place to record the number of positives in each subsegment, and a place for total score for the first 18 symptoms (just add them up).

The initial scales also have symptom screens for 3 other co-morbidities—oppositional-defiant, conduct, and anxiety/depression. These are screened by the number of positive responses in each of the segments separated by the "squares." The specific item sets and numbers of positives required for each co-morbid symptom screen set are detailed below.

The second section of the scale has a set of performance measures, scored 1 to 5, with 4 and 5 being somewhat of a problem/problematic. To meet criteria for ADHD there must be at least one item of the Performance set in which the child scores a 4 or 5; ie, there must be impairment, not just symptoms to meet diagnostic criteria. The sheet has a place to record the number of positives (4s, 5s) and an Average Performance Score—add them up and divide by number of Performance criteria answered.

Parent Assessment Scale	Teacher Assessment Scale
Predominantly Inattentive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	Predominantly Inattentive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Predominantly Hyperactive/Impulsive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	Predominantly Hyperactive/Impulsive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
ADHD Combined Inattention/Hyperactivity ■ Requires the above criteria on both inattention and hyperactivity/impulsivity	ADHD Combined Inattention/Hyperactivity ■ Requires the above criteria on both inattention and hyperactivity/impulsivity
Oppositional-Defiant Disorder Screen ■ Must score a 2 or 3 on 4 out of 8 behaviors on questions 19–26 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	Oppositional-Defiant/Conduct Disorder Screen ■ Must score a 2 or 3 on 3 out of 10 items on questions 19–28 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Conduct Disorder Screen ■ Must score a 2 or 3 on 3 out of 14 behaviors on questions 27–40 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	Anxiety/Depression Screen ■ Must score a 2 or 3 on 3 out of 7 items on questions 29–35 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Anxiety/Depression Screen ■ Must score a 2 or 3 on 3 out of 7 behaviors on questions 41–47 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	

The parent and teacher follow-up scales have the first 18 core ADHD symptoms, not the co-morbid symptoms. The section segment has the same Performance items and impairment assessment as the initial scales, and then has a side-effect reporting scale that can be used to both assess and monitor the presence of adverse reactions to medications prescribed, if any.

Scoring the follow-up scales involves only calculating a total symptom score for items 1–18 that can be tracked over time, and the average of the Performance items answered as measures of improvement over time with treatment.

Parent Assessment Follow-up

- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.

Teacher Assessment Follow-up

- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.

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SAMPLE **NICHQ Vanderbilt Assessment Scale—PARENT Informant**

Today's Date: *4-7-02* Child's Name: *John Doe* Date of Birth: *10-18-94*

Parent's Name: *Jane and Louis Doe* Parent's Phone Number: *555-1212*

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☑ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	(2)	3
2. Has difficulty keeping attention to what needs to be done	0	1	(2)	3
3. Does not seem to listen when spoken to directly	0	1	(2)	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	(2)	3
5. Has difficulty organizing tasks and activities	0	1	(2)	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	(3)
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	(2)	3
8. Is easily distracted by noises or other stimuli	0	1	(2)	3
9. Is forgetful in daily activities	0	1	2	(3)
10. Fidgets with hands or feet or squirms in seat	0	1	2	(3)
11. Leaves seat when remaining seated is expected	0	1	(2)	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	(3)
13. Has difficulty playing or beginning quiet play activities	0	(1)	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	(1)	2	3
15. Talks too much	0	1	(2)	3
16. Blurts out answers before questions have been completed	0	1	(2)	3
17. Has difficulty waiting his or her turn	0	1	2	(3)
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	(2)	3
19. Argues with adults	0	(1)	2	3
20. Loses temper	0	(1)	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	(1)	2	3
22. Deliberately annoys people	(0)	1	2	3
23. Blames others for his or her mistakes or misbehaviors	(0)	1	2	3
24. Is touchy or easily annoyed by others	0	(1)	2	3
25. Is angry or resentful	0	(1)	2	3
26. Is spiteful and wants to get even	(0)	1	2	3
27. Bullies, threatens, or intimidates others	(0)	1	2	3
28. Starts physical fights	(0)	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	(0)	1	2	3
30. Is truant from school (skips school) without permission	(0)	1	2	3
31. Is physically cruel to people	(0)	1	2	3
32. Has stolen things that have value	(0)	1	2	3
33. Deliberately destroys others' property	(0)	1	2	3

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SAMPLE **NICHQ Vanderbilt Assessment Scale—PARENT Informant**

Today's Date: *4-7-02* Child's Name: *John Doe* Date of Birth: *10-18-94*

Parent's Name: *Jane and Louis Doe* Parent's Phone Number: *555-1212*

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☑ was not on medication ☐ not sure?

Symptoms (continued)	Never	Occasionally	Often	Very Often
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	(0)	1	2	3
35. Is physically cruel to animals	(0)	1	2	3
36. Has deliberately set fires to cause damage	(0)	1	2	3
37. Has broken into someone else's home, business, or car	(0)	1	2	3
38. Has stayed out at night without permission	(0)	1	2	3
39. Has run away from home overnight	(0)	1	2	3
40. Has forced someone into sexual activity	(0)	1	2	3
41. Is fearful, anxious, or worried	0	(1)	2	3
42. Is afraid to try new things for fear of making mistakes	0	(1)	2	3
43. Feels worthless or inferior	0	(1)	2	3
44. Blames self for problems, feels guilty	0	(1)	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	(0)	1	2	3
46. Is sad, unhappy, or depressed	0	(1)	2	3
47. Is self-conscious or easily embarrassed	0	(1)	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	(4)	5
49. Reading	1	2	3	4	(5)
50. Writing	1	2	3	(4)	5
51. Mathematics	1	2	(3)	4	5
52. Relationship with parents	1	2	3	(4)	5
53. Relationship with siblings	1	2	3	(4)	5
54. Relationship with peers	1	2	3	(4)	5
55. Participation in organized activities (eg, teams)	1	2	(3)	4	5

Comments:

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Total number of questions scored 2 or 3 in questions 1–9: *9*

Total number of questions scored 2 or 3 in questions 10–18: *7*

Total Symptom Score for questions 1–18: *39*

Total number of questions scored 2 or 3 in questions 19–26: *0*

Total number of questions scored 2 or 3 in questions 27–40: *0*

Total number of questions scored 2 or 3 in questions 41–47: *0*

Total number of questions scored 4 or 5 in questions 48–55: *6*

Average Performance Score: *3.9*

Physician Note: John Doe met DSM criteria for ADHD Combined Inattention/Hyperactivity.

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Cover Letter to Teachers

Dear Teacher:

The parents of one of your students are seeking to have their child evaluated by our office for a health concern. As part of our evaluation process, we ask that both the child's parents and teacher complete a set of behavioral rating scales. This information is important for the diagnosis and treatment of your student.

Your time and cooperation in this matter is greatly appreciated. Attached please find a Release of Information Form that the parents have completed and a set of teacher rating scales and questionnaires. These forms include:

1. NICHQ Vanderbilt Teacher Assessment Scale
2. _____
3. _____
4. _____

Generally, the teacher who spends the most time with the child should complete the teacher rating scales. However, if the child has more than one primary teacher, or has a special education teacher, it would be useful for us to obtain a separate set of rating scales from each teacher. If more than one set of rating scales is required, please have the parent contact us directly at _____ and we will forward additional rating scales as needed. Please note that the same teacher should complete each entire set of forms.

Please fill out the forms as completely as possible. If you do not know the answer to a question, please write, "Don't know," so that we can be sure the item was not simply overlooked. Some of the questions in the rating scales may seem redundant. This is necessary to ensure that we obtain accurate diagnostic information.

We ask that you complete these forms as soon as possible, as we are unable to begin a child's evaluation without the teacher rating scales. **The forms should be mailed to us directly in the envelope provided.**

Thank you for your assistance and cooperation in the completion of these forms. If you have any questions regarding the enclosed materials, or if you would like additional information regarding services provided, please do not hesitate to contact us.

Sincerely,

John Doe, MD
Clinical Director
Pediatric Clinic
Pediatric Clinic Address
Pediatric Clinic Phone Number
Pediatric Clinic Fax Number

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ADHD Management Plan—Sample 1

Date:_____

To the family of_____, please refer to this plan between visits if you have questions about care.

If you are still unsure, call us at _____ for assistance.

Patient _____'s doctor is_____ Pager #_____

Parent/Guardian_____ Relationship_____

Contact Number(s)_____

School Name_____ School Phone No. _____ Fax No._____

Key Teacher Contact Name _____ Grade _____ Teacher's E-mail Address_____

Goals What improvements would you most like to see? Specific behavior you would like to see improve:

At Home:_____

_____

At School:_____

_____

Plans to reach these goals:

1._____

2._____

3._____

Medication

1._____ Time_____ am/pm Time_____ am/pm Time_____ am/pm
Dose 1_____ mg Dose 2_____ mg Dose 3 _____ mg

2._____ Time_____ am/pm Time_____ am/pm Time_____ am/pm
Dose 1 _____ mg Dose 2_____ mg Dose 3 _____ mg

☐ Medication to be given on nonschool days ☐ Medication given for_____ number of days
☐ School authorization signed by parent and MD ☐ Rx written for duplicate bottle for administration at school
☐ Side effects explained/information given

Common Side Effects: decreased appetite, sleep problems, transient stomachache, transient headache, behavioral rebound
Call your doctor immediately if any infrequent side effects occur: weight loss, increased heart rate and/or blood pressure, dizziness, growth suppression, hallucinations/mania, exacerbation of tics and Tourette syndrome (rare)

Further Evaluation

☐ School testing scheduled date _____
☐ Parent and Teacher Vanderbilts completed _____

Additional Resources and Treatment Strategies

☐ F/U Parent Vanderbilt given completed _____
☐ F/U Teacher Vanderbilt given to parent ☐ F/U Teacher Vanderbilt to be faxed to school completed _____
☐ Behavioral Modification Counseling Referral to _____
☐ Parenting Tips Sheet given ☐ CHADD phone number given: 800/233-4050
☐ Community Resources/Referrals: _____

_____

Next Follow-up Visit: _____

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ADHD Management Plan—Sample 2

Patient _____'s doctor is _____ Pager #_____

Parent/Guardian _____ Relationship _____

Contact Number(s) _____

School Name _____ School Phone No. _____

Key Teacher Contact Name _____ Grade Level _____

Teacher's E-mail Address _____ Fax No. _____

Goals What improvements would you most like to see?

_____

_____

_____

Plans to reach these goals:

1. _____
2. _____
3. _____

Medication

1. _____	Time _____ am/pm	Time _____ am/pm	Time _____ am/pm
	Dose 1 _____ mg	Dose 2 _____ mg	Dose 3 _____ mg
2. _____	Time _____ am/pm	Time _____ am/pm	Time _____ am/pm
	Dose 1 _____ mg	Dose 2 _____ mg	Dose 3 _____ mg

Further Evaluation

☐ Parent Assessment received and follow-up appointment scheduled for ____/____/____

☐ Teacher Assessment will be done by Ms/Mr _____

☐ School testing scheduled on this date ____/____/____

Additional Resources and Treatment Strategies

☐ Behavioral Modification Counseling Referral to _____

☐ Parenting Tips Sheet given

☐ Parent Follow-up form completed ____/____/____

☐ Teacher Follow-up form completed ____/____/____

☐ CHADD phone number given: 800/233-4050

Common Side Effects	If Any Infrequent Side Effects Occur, Call Your Doctor Immediately!
Decreased appetite	Weight loss
Sleep problems	Increased heart rate and/or blood pressure
Transient headache	Dizziness
Transient stomachache	Growth suppression
Behavioral rebound	Hallucinations/mania
	Exacerbation of tics and Tourette syndrome (rare)

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How to Establish a School-Home Daily Report Card

1. Select the Areas for Improvement.

- Discuss the child's behavior with all school staff who work with the child.
- Determine the child's greatest areas of impairment.
- Define goals toward which the child should be working regarding the areas of impairment.
- Key domains:
  - –Improving peer relations
  - –Improving academic work
  - –Improving classroom rule-following and relationships with adults

2. Determine How the Goals Will Be Defined.

- Identify specific behaviors ("target behaviors") that can be changed to make progress toward the goals easier.
- Target behaviors must be meaningful and clearly defined/observed/counted by teacher and child.
- Examples of target behaviors in the key domains:
  - –Improving peer relations: does not interrupt other children during their work time, does not tease other children, plays without fighting at recess
  - –Improving academic work: has materials and assignments necessary to do tasks, completes assigned academic tasks, is accurate on assigned tasks, completes and returns homework
  - –Improving classroom rule-following and relationships with adults: obeys the teacher when commands are given, does not talk back to the teacher, follows classroom rules
- Additional target behaviors are listed on the attached sheet, Sample Report Card Targets.

3. Decide on Behaviors and Criteria for the Daily Report Card.

- Estimate how often the child is doing the target behaviors by reviewing school records and/or observation.
- Determine which behaviors need to be included on the report.
- Evaluate target behaviors several times throughout the day.
- Set a reasonable criterion for each target behavior (a criterion is a target level the child will have to meet to receive a positive mark for that behavior). Set criteria to be met for each part of the day, not the overall day (eg, "interrupts fewer than 2 times in each class period" rather than "interrupts fewer than 12 times per day").

4. Explain the Daily Report Card to the Child.

- Meet with teacher, parents, and child.
- Explain all aspects of the Daily Report Card (DRC) to the child in a positive manner.

5. Establish a Home-based Reward System.

- Rewards must be selected by the child.
- Arrange awards so that:
  - –Fewer or less preferred rewards can be earned for fewer yeses.
  - –More desired rewards can be earned for better performance.
- Give the child a menu of rewards (see Sample Home and School Rewards):
  - –Select rewards for each level.
  - –Label the different levels with child-appropriate names (eg, One-Star Day, Two-Star Day).
  - –Use the Weekly Daily Report Card Chart to track weekly performance.
  - –Some children need more immediate rewards than the end-of-day home rewards—in such cases, in-school rewards can be used.

6. Monitor and Modify the Programs.

- Record daily the number of yeses the child received on each target.
- Once the child has regularly begun to meet the criterion, make the criteria harder (if the child is regularly failing to meet the criterion, make the criteria easier).
- Once the criterion for a target is at an acceptable level and the child is consistently reaching it, drop that target behavior from the DRC. (Let the child know why it was dropped and replace with another target if necessary.)
- Move to a weekly report/reward system if the child is doing so well that daily reports are no longer necessary.
- The report card can be stopped when the child is functioning within an appropriate range within the classroom, and reinstated if problems begin to occur again.

7. Troubleshooting a Daily Report Card.

- If the system is not working to change the child's behavior, examine the program and change where appropriate (see Troubleshooting a Daily Report Card).

8. Consider Other Treatments.

- If, after troubleshooting and modification, the DRC is not resulting in maximal improvement, consider additional behavioral components (eg, more frequent praise, time-out) and/or more powerful or intensive behavioral procedures (eg, a point system).

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Troubleshooting a Daily Report Card

Problem	Solution
Is the child taking the Daily Report Card (DRC) home?	Ensure that the child has a backpack or special folder in which to carry DRC. Have the teacher for last class of the day prompt the child to take DRC home. Assume the child received a negative report if he or she does not have DRC. Implement positive consequences for bringing home DRC.
Are the target behaviors appropriate? Are the target behaviors clearly defined for the child? Are the target behaviors socially valid? Can the target behaviors be reasonably attained in the classroom context?	Redefine the target behaviors for the child. Modify the target behaviors. Modify the target behaviors or class context (eg, "gets along with peers" should not be a target if the class structure does not provide the opportunity for peer interactions).
Does the child remember the target behaviors throughout the day?	Implement a system of visual prompts (eg, put task sheet on desk).
Are the criteria for success realistic (eg, not too high or too low relative to baseline)?	Modify the criteria to shape the behavior.
Is something interfering with the child's reaching the criteria (eg, child does not complete assignments due to messy, disorganized desk)?	Work on removing the impediment (eg, work on improving organizational skills, modify class schedule or structure).
Does the child understand the system? Can the child accurately describe the target behaviors and criteria for positive evaluations? Can the child accurately describe the relationship between the criteria and the rewards?	Implement a system of visual prompts, if necessary. Review system with child until child can accurately describe system. Increase frequency of reviewing if child continues to have difficulty. Explain the DRC system to the child again. Simplify the DRC system if necessary.
Is the monitoring system working properly? Have the target behaviors been sufficiently clearly defined that the teacher can monitor and evaluate them? Is the monitoring and recording process efficient enough so that the teacher is doing it accurately and consistently?	Modify the definitions of the target behaviors. Provide visual or auditory prompts for recording. Simplify the monitoring or recording process.
Can the child accurately monitor his or her progress throughout the day?	Design and implement a monitoring system that includes a recording form for the child (may include visual or auditory prompts).
Is the child receiving sufficient feedback so that he or she knows where he or she stands regarding the criteria?	Modify the teacher's procedures for providing feedback to the child (eg, provide visual prompts; increase immediacy, frequency, or contingent nature of feedback).
Is the home-based reward system working properly? Are the home-based rewards motivating for the child?	Change the home-based rewards (eg, increase the number of choices on menu, change the hierarchy of rewards).
Has it been ensured the child does not receive the reward noncontingently?	Review reward procedures with parents again and ensure that reward is provided only when the child has earned it.
Are the parents delivering the rewards reliably?	Modify the procedures for delivering the home-based rewards (eg, visual prompts) or the nature of the home-based rewards.
Can the child delay gratification long enough for home-based rewards to be effective?	Design and implement procedures for providing school-based rewards.

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Daily Home Report Card

Circle Y (Yes) or N (No)

Child's Name _____ Medication _____ Week/Month_____/_____

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
1._____	Y N	Y N	Y N	Y N	Y N	Y N	Y N
2._____	Y N	Y N	Y N	Y N	Y N	Y N	Y N
3._____	Y N	Y N	Y N	Y N	Y N	Y N	Y N
4._____	Y N	Y N	Y N	Y N	Y N	Y N	Y N
5._____	Y N	Y N	Y N	Y N	Y N	Y N	Y N
6._____	Y N	Y N	Y N	Y N	Y N	Y N	Y N
7._____	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Total number of Yeses							
Total number of Nos							

Comments:

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Daily School Report Card

Circle Y (Yes) or N (No)

Child's Name _____ Medication _____ Today's Date_____

	Subjects/Times						
1._____	Y N	Y N	Y N	Y N	Y N	Y N	Y N
2._____	Y N	Y N	Y N	Y N	Y N	Y N	Y N
3._____	Y N	Y N	Y N	Y N	Y N	Y N	Y N
4._____	Y N	Y N	Y N	Y N	Y N	Y N	Y N
5._____	Y N	Y N	Y N	Y N	Y N	Y N	Y N
6._____	Y N	Y N	Y N	Y N	Y N	Y N	Y N
7._____	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Teacher's Initials							
Total number of Yeses							
Total number of Nos							

Comments:

Sample Report Card Targets

Academic Productivity
Completes X assignments within the specified time
Completes X assignments with X% accuracy

Starts work with X or fewer reminders

Leaves appropriate spaces between words X% of the time or assignment
Writes legibly/uses 1-line cross outs instead of scribbles/writes on the lines of the paper
Corrects assignments appropriately*
Turns in assignments appropriately*

Following Classroom Rules
Follows class/school rules with X or fewer violations
Interrupts class less than X times per period/Works quietly with X or fewer reminders/Makes X or fewer inappropriate noises
Follows directions with X or fewer repetitions
Stays on task with X or fewer reminders
Sits appropriately* in assigned area with X or fewer reminders

Raises hand to speak with X or fewer reminders
Uses materials or possessions appropriately*
Has XX or fewer instances of stealing
Has XX or fewer instances of cursing
Has XX or fewer instances of complaining/crying/whining
Has XX or fewer instances of lying

Has XX or fewer instances of destroying property

Peer Relationships
Shares/helps peers when appropriate with X or fewer reminders
Ignores negative behavior of others/Child shows no observable response to negative behavior of others
Teases peers X or fewer times per period
Fewer than X fights with peers
Speaks clearly (fewer than X prompts for mumbling)
Contributes to discussion (answers X questions orally)
Contributes to discussion (at least X unprompted, relevant, nonredundant contributions)
Fewer than X negative self comments
Minds own business with XX or fewer reminders
Needs XX or fewer reminders to stop bossing peers
Does not bother other children during seat work (fewer than X complaints from others)

Teacher Relationships
Accepts feedback appropriately* (no more than X arguments/ X% of arguments) following feedback
Appropriately* asks an adult for help when needed
Maintains appropriate* eye contact when talking to an adult with X/fewer than X prompts to maintain eye contact
Respects adults (talks back fewer than X times per period)
Complies with X% of teacher commands/requests/Fewer than X noncompliances per period

Behavior Outside the Classroom
Follows rules at lunch/recess/free time/gym/specials/assemblies/ bathroom/in hallway with X or fewer rule violations
Walks in line appropriately*/Follows transition rules with X or fewer violations
Follows rules of the bus with X or fewer violations
Needs XX or fewer warnings for exhibiting bad table manners (eg, playing with food, chewing with mouth open, throwing trash on the floor)
Changes into gym clothes/school clothes within X:XX minutes

Time-out Behavior
Serves time-outs appropriately*
Child serves a time-out without engaging in inappropriate behaviors
While serving a time-out, the child exhibits no more than X instances of negative behavior

Responsibility for Belongings
Brings DRC to teacher for feedback before leaving for the next class/activity
Responsible for own belongings (has belongings at appropriate* times according to the checklist/chart**)
Has materials necessary for class/subject area
Organizes materials and possessions according to checklist/chart**
Morning routine completed according to checklist/chart**
End of day routine completed appropriately according to checklist/chart**
Brings supplies to class with XX or fewer reminders/brings supplies to class according to checklist/chart**
Hangs up jacket/backpack with XX or fewer reminders
Takes lunchtime pill with X or fewer reminders
Has only materials needed for the assignment on desk

Homework
Brings completed homework to class
Writes homework in assignment book with X or fewer reminders
DRC is returned signed the next day by parent
Has all needed materials for homework in backpack at the end of the day

---

*"Appropriately" must always be defined by teacher for child.
**Checklist/chart must accompany target behavior and be displayed for child.

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Sample Home Rewards

Daily Rewards

Snacks
Dessert after dinner
Staying up X minutes beyond bedtime
Having a bedtime story/Reading with a parent for X minutes
Choosing a radio station in car
Extra bathtub time for X minutes
Educational games on computer for X minutes
Choosing family TV show
Talking on phone to friend (local call)
Video game time for X minutes
Playing outside for X minutes
Television time for X minutes
Listening to radio/stereo for X minutes
Other as suggested by child

Daily or Weekly Rewards

Going over to a friend's house to play
Having a friend come over to play
Allowance
Bike riding/skating/scootering/skateboarding (in neighborhood for daily reward; longer trip with family or at bike trail/skate park for weekly reward)
Special activity with mom or dad
Special time with mom or dad for X minutes
Earn day off from chores
Game of choice with parent/family
Other as suggested by child

Weekly Rewards

Making a long-distance call to relatives or friends
Going to the video arcade at the mall
Going fishing
Going shopping/going to the mall
Going to the movies
Going to the park
Getting ice cream
Bowling, miniature golf/Selecting something special at the store
Making popcorn
Having friend over to spend night
Going to friend's to spend night
Choosing family movie
Renting movie video
Going to a fast-food restaurant with parent and/or family
Watching taped TV shows
Free time for X minutes
Other as suggested by child

Sample School Rewards*

Talk to best friend
Listen to tape player (with headphones)
Read a book
Help clean up classroom
Clean the erasers
Wash the chalkboard
Be teacher's helper
Eat lunch outside on a nice day
Extra time at recess
Write on chalkboard
Use magic markers
Draw a picture
Choose book to read to the class
Read to a friend
Read with a friend
Care for class animals
Play "teacher"
See a movie/filmstrip
Decorate bulletin board
Be messenger for office
Grade papers
Have treats
Earn class party
Class field trip
Student of the Day/Month
Pop popcorn
Be a line leader
Visit the janitor
Use the computer
Make ice cream sundaes
Teach a classmate
Choose stickers
Take a good note home
Receive a positive phone call
Give lots of praise
Hide a special note in desk
Choose seat for specific time
Play card games
Receive award certificate
Take Polaroid pictures
Draw from "grab bag"
Eat at a special table
Visit the principal

Notes: Older children could save over weeks to get a monthly (or longer) reward as long as visuals (eg, pieces of picture of activity) are used; eg, camping trip with parent, trip to baseball game, purchase of a video game. Rewards for an individual child need to be established as a menu. Children may make multiple choices from the menu for higher levels of reward, or may choose a longer period of time for a given reward.

*Sample School Rewards can be added to the home-based reward system especially if a child is not responding appropriately to the Home Rewards. Teachers need to make sure that a child wants and will work for one of these School Rewards.

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Medication Management Information

Stimulant medication and dosage: Based on the patient's daily schedule and response to medication. Measure at baseline and periodically monitor: Height, weight, blood pressure, pulse, sleep, appetite, mood, tics, family goals, and side effects.

Stimulant Medications - Immediate Release

Active Ingredient	Drug Name	Dosing	Duration of Behavioral Effects*
Mixed salts of amphetamine (Dextroamphetamine/ Levoamphetamine)	• Adderall Tablets *(scored)*:5 mg (blue), 10 mg (blue), 20 mg (pink), and 30 mg (pink)	Start with 5 mg 1–2 times per day and increase by 5 mg each week until good control achieved. Maximum Recommended Daily Dose: 40 mg **Do not use in patients with Cardiac disease**	About 4–6 hours depending on dose
Dextroamphetamine	• Dexedrine Tablet: 5 mg (orange) •Dextrostat Tablet *(scored)*:5 mg (yellow) and 10 mg (yellow)	Tablet: Start with 5 mg 1–2 times per day and increase by 5 mg each week until good control achieved. Maximum Recommended Daily Dose: 40 mg	Tablet: 4–5 hours
Methylphenidate	• Ritalin Tablets *(scored)*:5, 10, and 20 mg •Methylin Tablets *(scored)*:5, 10, and 20 mg •Focalin Tablets: 2.5, 5, and 10 mg	Start with 5 mg (2.5 mg for Focalin) 1–2 times per day and increase by 5 mg each week until good control is achieved. May need third reduced dose in the afternoon. Maximum Recommended Daily Dose: 60 mg	3–4 hours

Stimulant Medications Sustained Release, continued on side 2

Active Ingredient	Drug Name	Dosing	Duration of Behavioral Effects*
Mixed salts of amphetamine (Dextroamphetamine/ Levoamphetamine)	• Adderall XR Capsule *(can be sprinkled)*: 10 mg (blue/blue), 20 mg (orange/orange), and 30 mg (natural/orange)	Start at 10 mg in the morning and increase by 10 mg each week until good control is achieved. Maximum Recommended Daily Dose: 40 mg **Do not use in patients with Cardiac disease**	8–12 hours
Dextroamphetamine	• Dexedrine Spansule Spansule *(can be sprinkled)*:5, 10, and 15 mg (orange/black)	Start at 5 mg in the morning and increase by 5 mg each week until good control is achieved. Maximum Recommended Daily Dose: 45 mg	8–10 hours
Methylphenidate	• Concerta Capsule *(noncrushable)*: 18, 27, 36, and 54 mg	Start at 18 mg each morning and increase by 18 mg each week until good control is achieved. Maximum Recommended Daily Dose: 72 mg	8–12 hours
	• Ritalin SR Tablet: 20 mg SR (white) • Ritalin LA Capsule *(can be sprinkled)*: 20, 30, and 40 mg	Start at 20 mg in the morning and increase by 20 mg each week until good control is achieved. May need second dose or regular methylphenidate dose in the afternoon. Maximum Recommended Daily Dose: 60 mg	4–8 hours

*These are estimates, as duration may vary with individual child.

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Stimulant Medications Sustained Release, continued

Active Ingredient	Drug Name	Dosing	Duration of Behavioral Effects
Methylphenidate (cont.)	•Metadate ER Tablet: 10 and 20 mg extended release •Methylin ER Tablet: 10 and 20 mg extended releases	Start at 10 mg each morning and increase by 10 mg each week until good control is achieved. May need second dose or regular methylphenidate dose in the afternoon. Maximum Recommended Daily Dose: 60 mg	4–8 hours
	•Metadate CD Capsule: 10, 20, and 30 mg extended release *(can be sprinkled)*:.	Start at 10 mg each morning and increase by 10mg mg each week until good control is achieved Maximum Recommended Daily Dose: 60 mg	4–8 hours

Contraindications and Side Effects

Active Ingredient	Contraindications *(Stimulants can be used in children with epilepsy.)*
Mixed salts of amphetamine	MAO Inhibitors within 14 days Glaucoma, Cardiovascular disease, Hyperthyroidism Moderate to severe hypertension
Dextroamphetamine	MAO Inhibitors within 14 days Glaucoma
Methylphenidate	MAO Inhibitors within 14 days Glaucoma Preexisting severe gastrointestinal narrowing Caution should be used when prescribing concomitantly with anticoagulants, anticonvulsants, phenylbutazone, and tricyclic antidepressants
Common Side Effects: • Decreased appetite • Sleep problems • Transient headache • Transient stomachache • Behavioral rebound	
Infrequent Side Effects: • Weight loss • Increased heart rate, blood pressure • Dizziness • Growth suppression • Hallucinations/mania • Exacerbation of tics and Tourette syndrome (rare)	
Possible Strategies for Common Side Effects: (If one stimulant is not working or produces too many adverse side effects, try another stimulant before using a different class of medications.) Decreased Appetite Behavioral Rebound Irritability/Dysphoria • Dose after meals • Try sustained-release stimulant • Decrease dose • Frequent snacks medication • Try another stimulant medication • Drug holidays • Add reduced dose in late afternoon • Consider coexisting conditions, especially depression Sleep Problems Exacerbation of Tics (rare) Psychosis/Euphoria/Mania/Severe • Bedtime routine • Observe Depression • Reduce or eliminate afternoon dose • Reduce dose • Stop treatment with stimulants • Move dosing regimen to earlier time • Try another stimulant or class of • Referral to mental health specialist • Restrict or eliminate caffeine medications	

Non Stimulant Medications

Active Ingredient	Drug Name	Dosing
Atomoxetine HCL	Strattera Capsule: 10mg, 18mg, 25mg, 40 mg, 60mg	Start as a single daily dose, based on weight, 0.5mg/kg/day for the first week then increase up to a max 1.4 mg/kg/day all given in 1 daily dose.

*These are estimates, as duration may vary with individual child. Note: Drugs listed on this handout do not appear in any order of importance.

Does My Child Have ADHD?

Many parents worry about this question. The answer comes from children, families, teachers, and doctors working together as a team. Watching your child's behavior at home and in the community is very important to help answer this question. Your doctor will ask you to fill out rating scales about your child. Watching your child's behavior and talking with other adults in the child's life will be important for filling out the forms.

Here are a few tips about what you can do to help answer the question:

Watch your child closely during activities where he or she should pay attention.

- ☐ Doing homework
- ☐ Doing chores
- ☐ During storytelling or reading

Watch your child when you expect him or her to sit for a while or think before acting.

- ☐ Sitting through a family meal
- ☐ During a religious service
- ☐ Crossing the street
- ☐ Being frustrated
- ☐ With brothers or sisters
- ☐ While you are on the phone

Pay attention to how the environment affects your child's behavior. Make changes at home to improve your child's behavior.

- ☐ Ensure that your child understands what is expected. Speak slowly to your child. Have your child repeat the instructions.
- ☐ Turn off the TV or computer games during meals and homework. Also, close the curtains if it will help your child pay attention to what he or she needs to be doing.
- ☐ Provide structure to home life, such as regular mealtimes and bedtime. Write down the schedule and put it where the entire family can see it. Stick to the schedule.
- ☐ Provide your child with planned breaks during long assignments.
- ☐ Give rewards for paying attention and sitting, not just for getting things right and finishing. Some rewards might be: dessert for sitting through a meal, outdoor play for finishing homework, and praise for talking through problems.
- ☐ Try to find out what things set off problem behaviors. See if you can eliminate the triggers.

If your child spends time in 2 households, compare observations.

- ☐ Consult your child's other parent about behavior in that home. Cooperation between parents in this area really helps the child.
- ☐ If the child behaves differently, consider differences in the environment that may explain the difference in behavior. Differences are common and not a mark of good or bad parenting.

Talk to your child's teacher.

- ☐ Learn about your child's behavior at school. Talk about how your child does during academic lessons and also during play with other children.
- ☐ Compare your child's behavior in subjects he or she likes and those in which he or she has trouble with the work.
- ☐ Determine how the environment at school affects your child's behavior. When does your child perform well? What events trigger problem behaviors?
- ☐ Consider with the teacher whether your child's learning abilities should be evaluated at school. If he or she has poor grades in all subjects or in just a few subjects or requires extra time and effort to learn material, then a learning evaluation may be valuable.

Gather impressions from other adult caregivers who know your child well.

- ☐ Scout leaders or religious instructors who see your child during structured activities and during play with other children
- ☐ Relatives or neighbors who spend time with your child
- ☐ Determine how other environments affect your child's behavior. When does your child perform well? What events trigger problem behaviors?

Make an appointment to see your child's doctor.

- ☐ Let the receptionist know you are concerned that your child might have ADHD.
- ☐ If possible, arrange a visit when both parents can attend.

Adapted from materials by Heidi Feldman, MD, PhD

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Evaluating Your Child for ADHD

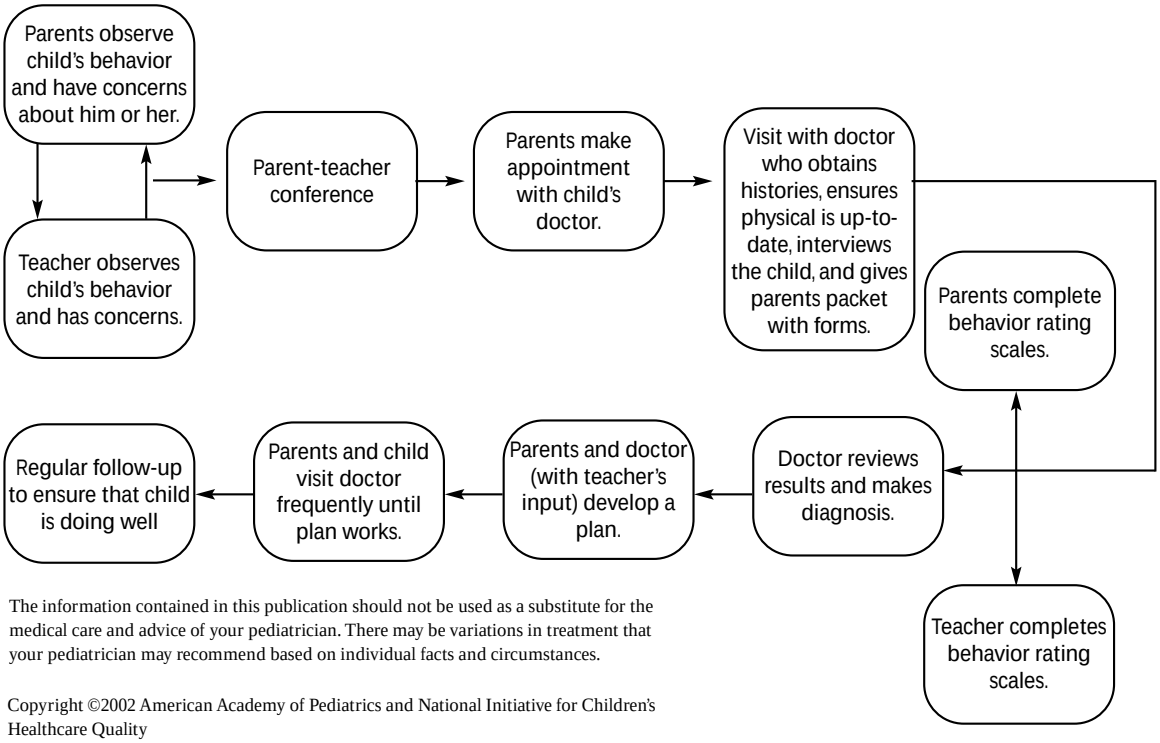
So you think your child may have ADHD, attention-deficit/hyperactivity disorder? Or your child's teacher thinks your child may have ADHD? There are steps that need to be taken to make a diagnosis of ADHD. Some children may have a learning disability, some children may have difficulty with their hearing or vision, and some children may actually have ADHD. The answer comes from the parents, other family members, doctors, and other professionals working as a team. Here are the steps that the *team* needs to take to evaluate your child.

The steps in an evaluation are as follows:

Step 1:	Parents make careful observations of the child's behavior at home.
Step 2:	Teacher(s) makes careful observations of the child at school.
Step 3:	Parents and the child's teacher(s) have a meeting about concerns.
Step 4:	Parents make an appointment with the child's doctor. Parents give the doctor the name and phone number of the teacher(s) and school.
Step 5:	The doctor obtains a history, completes a physical examination (if not done recently), screens the child's hearing and vision, and interviews the child.
Step 6:	Parents are given a packet of information about ADHD, including parent and teacher behavior questionnaires, to be filled out before the next visit.
Step 7:	The teacher(s) returns the questionnaire by mail or fax.
Step 8:	At a second doctor visit, the doctor reviews the results of the parent and teacher questionnaires and determines if any other testing is required to make a diagnosis of ADHD or other condition.
Step 9:	The doctor makes a diagnosis and reviews a plan for improvement with the parents.
Step 10:	The child will need to revisit the doctor until the plan is in place and the child begins to show improvement, and then regularly for monitoring. Parents and teachers may be asked to provide behavior ratings at many times in this process.

Adapted from materials by Heidi Feldman, MD, PhD

ADHD Evaluation Timeline



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General Tips

1. Rules should be clear and brief. Your child should know exactly what you expect from him or her.
2. Give your child chores. This will give him or her a sense of responsibility and boost self-esteem.
3. Short lists of tasks are excellent to help a child remember.
4. Routines are extremely important for children with ADHD. Set up regular times for meals, homework, TV, getting up, and going to bed. Follow through on the schedule!
5. Identify what your child is good at doing (like art, math, computer skills) and build on it.
6. Tell your child that you love and support him or her unconditionally.
7. Catch your child being good and give immediate positive feedback.

Common Daily Problems

It is very hard to get my child ready for school in the morning.

- Create a consistent and predictable schedule for rising and getting ready in the morning.
- Set up a routine so that your child can predict the order of events. Put this routine in writing or in pictures on a poster for your child. Schedule example:

  Alarm goes off → Brush teeth → Wash face → Get dressed → Eat breakfast → Take medication → Get on school bus

- Reward and praise your child! This will motivate your child to succeed. Even if your child does not succeed in all parts of the "morning routine," use praise to reward your child when he or she is successful. Progress is often made in a series of small steps!
- If your child is on medication, try waking your child up 30 to 45 minutes before the usual wake time and give him or her the medication immediately. Then allow your child to "rest" in bed for the next 30 minutes. This rest period will allow the medication to begin working and your child will be better able to participate in the morning routine.

My child is very irritable in the late afternoon/early evening. *(Common side effect of stimulant medications)*

- The late afternoon and evening is often a very stressful time for all children in all families because parents and children have had to "hold it all together" at work and at school.
- If your child is on medication, your child may also be experiencing "rebound"—the time when your child's medication is wearing off and ADHD symptoms may reappear.
- Adjust your child's dosing schedule so that the medication is not wearing off during a time of "high demand" (for example, when homework or chores are usually being done).
- Create a period of "downtime" when your child can do calm activities like listen to music, take a bath, read, etc.
- Alternatively, let your child "blow off extra energy and tension" by doing some physical exercise.
- Talk to you child's doctor about giving your child a smaller dose of medication in the late afternoon. This is called a "stepped down" dose and helps a child transition off of medication in the evening.

My child is losing weight or not eating enough. *(Common side effects of stimulant medication use)*

- Encourage breakfast with calorie-dense foods.
- Give the morning dose of medication after your child has already eaten breakfast. Afternoon doses should also be given after lunch.
- Provide your child with nutritious after-school and bedtime snacks that are high in protein and in complex carbohydrates. Examples: Nutrition/protein bars, shakes/drinks made with protein powder, liquid meals.
- Get eating started with any highly preferred food before giving other foods.
- Consider shifting dinner to a time later in the evening when your child's medication has worn off. Alternatively, allow your child to "graze" in the evening on healthy snacks, as he or she may be hungriest right before bed.
- Follow your child's height and weight with careful measurements at your child's doctor's office and talk to your child's doctor.

Homework Tips

- Establish a routine and schedule for homework (a specific time and place.) Don't allow your child to wait until the evening to get started.
- Limit distractions in the home during homework hours (reducing unnecessary noise, activity, and phone calls, and turning off the TV).
- Praise and compliment your child when he or she puts forth good effort and completes tasks. In a supportive, noncritical manner, it is appropriate and helpful to assist in pointing out and making some corrections of errors on the homework.
- It is not your responsibility to correct all of your child's errors on homework or make him or her complete and turn in a perfect paper.
- Remind your child to do homework and offer incentives: "When you finish your homework, you can watch TV or play a game."
- If your child struggles with reading, help by reading the material together or reading it to your son or daughter.
- Work a certain amount of time and then stop working on homework.

"Common Daily Problems" adapted from material developed by Laurel K. Leslie, MD, San Diego ADHD Project.

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- Many parents find it very difficult to help their own child with schoolwork. Find someone who can. Consider hiring a tutor! Often a junior or senior high school student is ideal, depending on the need and age of your child.

Discipline

- Be firm. Set rules and keep to them.
- Make sure your child understands the rules, so he or she does not feel uninformed.
- Use positive reinforcement. Praise and reward your child for good behavior.
- Change or rotate rewards frequently to maintain a high interest level.
- Punish behavior, not the child. If your child misbehaves, try alternatives like allowing natural consequences, withdrawing yourself from the conflict, or giving your child a choice.

Taking Care of Yourself

- Come to terms with your child's challenges and strengths.
- Seek support from family and friends or professional help such as counseling or support groups.
- Help other family members recognize and understand ADHD.

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What Can I Do When My Child Has Problems With Sleep?

Many children with ADHD have difficulty sleeping at night, whether or not they are on medication. This is partially related to the ADHD; parents often describe their children as being "on the go" and collapsing late at night. It may also be due to the fact that stimulant medication has worn off, making it more difficult for them to manage their behavior. Lastly, some children have difficulty falling asleep because the stimulants affect them the same way caffeine affects adults.

Here are a few tips:

- **Develop bedtime rituals/routines.**
  - ☐ A bedtime ritual is a powerful sign that it is time to sleep. It needs to be simple so the child can "re-create" the ritual even if the parent is not present.
  - ☐ Try writing out the bedtime ritual to make it consistent.
- **Pay attention to the sleep environment.**
  - ☐ Background noises, location, sleep partners, bedding, favorite toys, and lighting can all affect a child's ability to fall asleep.
  - ☐ A cool, dark, quiet room is best.
- **Letting children cry themselves to sleep is not recommended.**
  - ☐ Teach them to soothe themselves, such as giving the child a special blanket, a picture of the parent(s), or a stuffed animal to hold while falling asleep.
  - ☐ Avoid activities that depend on a parent's presence, including rocking or holding the child until he or she falls asleep.
- **Make the bedroom a sleep-only zone.**
  - ☐ Remove most toys, games, televisions, computers, and radios from your child's bedroom if your child is having trouble falling asleep or is often up at night.
  - ☐ One or two stuffed animals are acceptable.
- **Limit time in bed.**
  - ☐ Hours spent awake in bed interfere with good sleep patterns; the goal is to make the child's bed a place for sleeping only.
  - ☐ Be aware of how much sleep children need at different ages. Even though adults need about 8 hours of sleep, infants and toddlers often sleep more than 12 hours and children usually sleep 10 hours. Teenagers also need lots of sleep, sometimes requiring 9 hours or more.
- **Establish consistent waking times.**
  - ☐ Bedtimes and waking times should be the same 7 days a week.
  - ☐ It is easier to enforce a waking time than a bedtime.
- **Avoid drinks with caffeine.**
  - ☐ Caffeine is present in a wide range of beverages, such as tea, soda, cocoa, and coffee. Drinking these beverages past the afternoon may make it more difficult for your child to settle down to sleep.
- **Establish daytime routines.**
  - ☐ Regular mealtimes and activity times, including playtime with parents, also help set sleep times.
- **Chart your child's progress.**
  - ☐ Praise your child for successful quiet nights.
  - ☐ Consider marking successful nights on a star chart and providing rewards at the end of the week.
- **Waking up at night is a habit.**
  - ☐ Social contact with parents, feeding, and availability of interesting toys encourage the child to be up late, so set limits on attention-getting behaviors at night.
- **Consider medical problems.**
  - ☐ Allergy, asthma, or conditions that cause pain can disrupt sleep. If your child snores loudly and/or pauses in breathing, talk to your doctor.
- **Try medications to help your child sleep only under the care of your child's doctor.**
  - ☐ Medications need to be used very carefully in young children. Many medications can have complications and make sleep worse.
  - ☐ Some children with ADHD may actually be helped by a small dose of a stimulant medication at bedtime. Paradoxically, this dose may help a child to get organized for sleep.
  - ☐ Some children may ultimately need other bedtime medications—at least for a little while—to help improve sleep. Talk with your doctor before starting any over-the-counter or prescription medications.

Adapted from material developed by Laurel K. Leslie, MD, San Diego ADHD Project, and from material developed by Henry L. Shapiro, MD, FAAP, for the Pediatric Development and Behavior Web site (www.dbpeds.org).

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There are 2 main laws protecting students with disabilities—including those with ADHD: 1) the Individuals with Disabilities Education Act of 1997 **(IDEA)** and 2) **Section 504** of the Rehabilitation Act of 1973. IDEA is special education law. Section 504 is a civil rights statute. Both laws guarantee to qualified students a free and appropriate public education (FAPE) and instruction in the least restrictive environment (LRE), which means with their peers who are not disabled and to the maximum extent appropriate to their needs.

Because there are different criteria for eligibility, services/supports available, and procedures and safeguards for implementing the laws, it is important for parents, educators, clinicians, and advocates to be well aware of the variations between IDEA and Section 504 and fully informed about the respective advantages and disadvantages.

Additional Resources

1. *Advocacy Manual: A Parents' How-to Guide for Special Education Services* Learning Disabilities Association of America, 1992. Contact the publisher at 4156 Library Rd, Pittsburgh, PA 15243 or 888/300-6710.
2. *Better IEPs: How to Develop Legally Correct and Educationally Useful Programs* Barbara Bateman and Mary Anne Linden, 3rd edition, 1998. Contact the publisher, Sopris West, at 303/651-2829 or http://www.sopriswest.com.
3. *The Complete IEP Guide: How to Advocate for Your Special Ed Child* Lawrence Siegel, 2nd edition, 2000. Contact the publisher, Nolo, at 510/549-1976 or http://www.nolo.com.
4. *Negotiating the Special Education Maze: A Guide for Parents and Teachers* Winifred Anderson, Stephen Chitwood, and Deidre Hayden; 3rd edition; 1997. Contact the publisher, Woodbine House, at 6510 Bells Mill Rd, Bethesda, MD 20817 or 800/843-7323.
5. Children and Adults With Attention-Deficit/Hyperactivity Disorder http://www.chadd.org
6. Education Resources Information Center http://ericir.syr.edu
7. Internet Resource for Special Children http://www.irsc.org
8. San Diego ADHD Web Page http://www.sandiegoadhd.org
9. National Information Center for Children and Youth with Disabilities http://www.nichcy.org
10. Parent Advocacy Coalition for Educational Rights Center http://www.pacer.org

Glossary of Acronyms

ADHD
Attention-deficit/hyperactivity disorder

BIP
Behavioral Intervention Plan

ED
Emotional disturbance

FAPE
Free and appropriate public education

FBA
Functional Behavioral Assessment

IDEA
Individuals with Disabilities Education Act

IEP
Individualized Education Program

IST
Instructional Support Team

LRE
Least restrictive environment

MDR
Manifestation Determination Review

MDT
Multidisciplinary Team

OHI
Other health impaired

SLD
Specific learning disability

SST
Student Study Team

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IDEA

Who Is Eligible?

IDEA strongly emphasizes the provision of special education and related services that enable students to access and progress in the general education program. Sometimes students with ADHD qualify for special education and related services under the disability categories of "specific learning disability" (SLD) or "emotional disturbance" (ED). For example, a child who has ADHD who also has coexisting learning disabilities may be eligible under the SLD category. Students with ADHD most commonly are eligible for special education and related services under the IDEA category of "other health impaired" (OHI). Eligibility criteria under this category require that the child has a chronic or acute health problem (eg, ADHD) causing limited alertness to the educational environment (due to heightened alertness to environmental stimuli) that results in an adverse effect on the child's educational performance to the degree that special education is needed.

Note: *The adverse effect on educational performance is not limited to academics, but can include impairments in other aspects of school functioning, such as behavior, as well.*

How Does a Parent Access Services Under IDEA?

- **Parents or school personnel may refer a child** by requesting an evaluation to determine eligibility for special education and related services. It is best to put this request in writing.
- Within a limited time frame, **the school's multidisciplinary evaluation team, addressing all areas of the child's difficulties, develops an assessment plan.**
- After parents or guardians consent to the assessment plan, **the child receives a comprehensive evaluation** by the multidisciplinary team of school professionals.
- After the evaluation, **an Individualized Education Program (IEP) meeting is scheduled** with the team, including parents, teacher(s), special education providers, the school psychologist and/or educational evaluator, a school system representative, and the student (as appropriate).
- Based on the results of the evaluation, as well as other input provided by parents and/or other team members, **the team decides whether the child meets eligibility criteria** for special education under one of the categories defined by IDEA.
- **An IEP is developed and written for qualifying students through a collaborative team effort.** It is tailored and designed to address the educational needs of the student.
- The **IEP goes into effect** once the parents sign it and agree to the plan.
- The IEP must address the following:
  - Present levels of educational performance, including how the child's disability affects his or her involvement and progress in the general curriculum
  - Delineation of all special education and related services, modifications (if any), and supports to be provided to the child or on behalf of the child
  - Annual goals and measurable, short-term objectives/ benchmarks
  - The extent (if any) to which the child will not participate with children in the regular class and other school activities
  - Modifications (if any) in the administration of statewide and district-wide tests the child will need to participate in those assessments
  - Dates and places specifying when, where, and how often services will be provided, and by whom

What Happens After the IEP Is Written?

1. Services are provided. These include all programs, supplemental aids, program modifications, and accommodations that are spelled out in the IEP.
2. Progress is measured and reported to parents. Parents are informed of progress toward IEP goals during the year, and an annual IEP review meeting is required.
3. Students are reevaluated every 3 years (triennial evaluation) or sooner if deemed necessary by the team or on parent/ teacher request.

Adapted from Rief S. *The ADD/ADHD Book of Lists.* San Francisco, CA: Jossey-Bass Publishers; 2002, and from material developed by Laurel K. Leslie, MD, San Diego ADHD Project.

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Section 504

Who Is Eligible?

Students with ADHD also may be protected under Section 504 of the Rehabilitation Act of 1973 (even if they do not meet eligibility criteria under IDEA for special education). To determine eligibility under Section 504 (ie, the impact of the disability on learning), the school is required to do an assessment. This typically is a much less extensive evaluation than that conducted for the IEP process. Section 504 is a federal civil rights statute that:

- Protects the rights of people with disabilities from discrimination by any agencies receiving federal funding (including all public schools)
- Applies to students with a record of (or who are regarded as having) a physical or mental impairment that substantially limits one or more major life function (which includes learning)
- Is intended to provide students with disabilities equal access to education and commensurate opportunities to learn as their peers who are not disabled

How Does a Parent Access Services Under Section 504?

- **Parents or school personnel may refer a child** by requesting an evaluation to determine eligibility for special education and related services. It is best to put this request in writing.
- **If the school determines that the child's ADHD *does* significantly limit his or her learning,** the child would be eligible for a 504 plan designating:
  - –Reasonable accommodations in the educational program
  - –Related aids and services, if deemed necessary (eg, counseling, assistive technology)

What Happens After the 504 Plan Is Written?

The implementation of a 504 plan typically falls under the responsibility of general education, not special education. A few sample classroom accommodations may include:

- Tailoring homework assignments
- Extended time for testing
- Preferential seating
- Supplementing verbal instructions with visual instructions
- Organizational assistance
- Using behavioral management techniques
- Modifying test delivery

What Do Section 504 and IDEA Have in Common?

Both:

- Require school districts to provide free and appropriate public education (FAPE) in the least restrictive environment (LRE)
- Provide a variety of supports (adaptations/accommodations/modifications) to enable the student to participate and learn in the general education program
- Provide an opportunity for the student to participate in extracurricular and nonacademic activities
- Require nondiscriminatory evaluation by the school district
- Include due process procedures if a family is dissatisfied with a school's decision

Which One Is Right for My Child—a 504 Plan or an IEP?

This is a decision that the team (parents and school personnel) must make considering eligibility criteria and the specific needs of the individual student. For students with ADHD who have more significant school difficulties:

IDEA usually is preferable because:

- It provides for a more extensive evaluation.
- Specific goals and short-term objectives are a key component of the plan and regularly monitored for progress.
- There is a much wider range of program options, services, and supports available.
- It provides funding for programs/services (Section 504 is non-funded).
- It provides more protections (procedural safeguards, monitoring, regulations) with regard to evaluation, frequency of review, parent participation, disciplinary actions, and other factors.

A 504 plan would be preferable for:

- Students who have milder impairments and don't need special education. A 504 plan is a faster, easier procedure for obtaining accommodations and supports.
- Students whose educational needs can be addressed through adjustments, modifications, and accommodations in the general curriculum/classroom.

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Sample Letter #1:
Request for Assessment for Educational Services Under Section 504

(Date)

School Site Principal's Name
School Name
Address

RE: **(Student's Name and Grade)**

Dear **(Principal's Name)*:**

I am the parent of **(Student's Name),** who is in Mr/Ms **(Teacher's Name)'s** class. **(Student's Name)** has been experiencing school problems for some time now. We have been working with the teacher(s) to modify **(his/her)** regular education program but **(we have not seen any improvement** or **the problems have been getting worse).** Therefore, I wish to request an assessment of my child for appropriate educational services and interventions according to the provisions of Section 504 of the Rehabilitation Act.

I look forward to working with you as soon as possible to develop an assessment plan to begin the evaluation process. I request copies of the assessment results 1 week prior to the meeting.

Thank you for your assistance. I can be reached by phone at **(Area Code and Phone Number).**
The best time to reach me is **(times/days).**

Sincerely,

(Sign Your Name)
(Print Your Name)
(Address)
(Telephone Number)

Adapted from San Diego Learning Disabilities Association.
http://ldasandiego.org/

Note: Remember to keep a copy for your files.
*If the principal does not respond, contact the district 504 coordinator. It is recommended that you either write a letter or document your phone conversation. If you do not get a response, you have the right to file a compliance complaint.

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Sample Letter #2:
Request for Assessment for Special Education

(Date)

School Site Principal's Name:
School Name
Address

RE: **(Student's Name and Grade)**

Dear **(Principal's Name)*:**

I am the parent of **(Student's name)** who is in Mr/Ms **(Teacher's Name)'s** class. **(Student's Name)** has been experiencing school problems for some time now. These problems include:_____

_____

We have been working with the teacher(s) to modify **(his/her)** regular education program but **(we have not seen any improvement** or **the problems have been getting worse).** Therefore, I wish to request an assessment of my child for possible special education services according to the provisions of IDEA.

I look forward to working with you within the next 15 days to develop an assessment to begin the evaluation process. Please ensure that I receive copies of the assessment results 1 week prior to the IEP meeting. Thank you for your assistance. I can be reached by phone at **(Area Code and Phone Number).** The best time to reach me is **(times/days).**

Sincerely,

Sign your name
Print your name
Street Address
City, State, ZIP

Doctor's Signature
License Number
Practice Address
City, State, ZIP

Adapted from San Diego Learning Disabilities Association.
http://ldasandiego.org/

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Homework Tips for Parents

- **Establish a routine and schedule for homework (a specific time and place)** and adhere to the schedule as closely as possible. Don't allow your child to wait until the evening to get started.
- **Limit distractions** in the home during homework hours (eg, reduce unnecessary noise, activity, and phone calls; turn off the TV).
- **Assist your child in dividing assignments into smaller parts** or segments that are more manageable and less overwhelming.
- **Assist your child in getting started on assignments** (eg, read the directions together, do the first items together, observe as your child does the next problem/item on his or her own). Then get up and leave.
- **Monitor and give feedback without doing all the work together.** You want your child to attempt as much as possible independently.
- **Praise and compliment your child when he or she puts forth good effort and completes tasks.** In a supportive, noncritical manner it is appropriate and helpful to assist in pointing out and making some corrections of errors on the homework.
- **It is not your responsibility to correct all of your child's errors on homework** or make him or her complete and turn in a perfect paper.
- **Remind your child to do homework and offer incentives:** "When you finish your homework, you can…"
- **A contract for a larger incentive/reinforcer may be worked out** as part of a plan to motivate your child to persist and follow through with homework. ("If you have no missing or late homework assignments this next week, you will earn. . .").
- **Let the teacher know your child's frustration and tolerance level in the evening.** The teacher needs to be aware of the amount of time it takes your child to complete tasks and what efforts you are making to help at home.
- **Help your child study for tests.** Study together. Quiz your child in a variety of formats.
- **If your child struggles with reading, help by reading the material together** or reading it to your son or daughter.
- **Work a certain amount of time and then stop working on homework.** Don't force your child to spend an excessive and inappropriate amount of time on homework. If you feel your child worked enough for one night, write a note to the teacher attached to the homework.
- It is very common for students with ADHD to fail to turn in their finished work. It is very frustrating to know your child struggled to do the work, but then never gets credit for having done it. Papers seem to mysteriously vanish off the face of the earth! **Supervise to make sure that completed work leaves the home and is in the notebook/backpack.** You may want to arrange with the teacher a system for collecting the work immediately on arrival at school.
- Many parents find it very difficult to help their own child with schoolwork. Find someone who can. **Consider hiring a tutor!** Often a junior or senior high school student is ideal, depending on the needs and age of your child.
- **Make sure your child has the phone number of a study buddy**—at least one responsible classmate to call for clarification of homework assignments.
- Parents, **the biggest struggle is keeping on top of those dreaded long-range homework assignments** (eg, reports, projects). This is something you will need to be vigilant about. Ask for a copy of the project requirements. Post the list at home and go over it together with your child. Write the due date on a master calendar. Then plan how to break down the project into manageable parts, scheduling steps along the way. Get started AT ONCE with going to the library, gathering resources, beginning the reading, and so forth.

Adapted from Rief S. *The ADD/ADHD Book of Lists.* San Francisco, CA: Jossey-Bass Publishers; 2002

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Working With Your Child's School

Why Is My Child Having Trouble in School?

It is very common for children with ADHD to have difficulties in school. These problems can occur for several reasons:

- Symptoms of ADHD like **distractibility and hyperactivity** make it hard for children with ADHD to pay attention or stay focused on their work, even though they may be capable learners and bright enough to understand the material.
- Many children with ADHD also have **trouble organizing** themselves, breaking an assignment down into smaller steps, and staying on a schedule.
- Some children with ADHD have **difficulty with self-control** and get into trouble with peers and/or teachers.
- Many children with ADHD also have **a learning disability.** Schools usually define a learning disability as a discrepancy between a child's IQ score and his or her performance on achievement tests. A child with a learning disability has difficulty understanding information he or she sees or hears OR trouble putting together information from different parts of the brain.
- Children with ADHD often **can learn material but it may take longer** and require more repetition.
- Children with ADHD often show **inconsistency in their work** because of their ADHD; one day they may know information and the next day they cannot seem to remember it.

Typical School Performance Difficulties Associated With ADHD

- Poor organization and study skills
- Weaknesses in written language/writing skills
- Minimal/inconsistent production and output (both in-class assignments and homework)
- Behavior that interferes with learning and impacts on interpersonal relationships
- Immature social skills

What Can I Personally Do to Help?

There are many different ways that a parent's participation can make a difference in a child's school experience, including:

- **Spending time** in the classroom, if your work schedule allows, and observing your child's behavior.
- **Talking with your child's teacher** to identify where your child is having the most problems.
- Working with your child's teacher to make a **plan** for how you will address these problems and what strategies at school and home will help your child be successful at learning and completing work.
- **Acknowledging the extra efforts your child's teacher** may have to make to help your child.
- **Reading all you can about ADHD** and sharing it with your child's teacher and other school officials.
- **Becoming an expert on ADHD and your child.**
- **Finding out about tutoring options** through your child's school or local community groups. Children with ADHD may take longer to learn material compared with other children even though they are just as smart. Tutoring may help your child master new materials.
- **Making sure your child actually has mastered** new material presented so that he or she does not get behind academically.
- **Acknowledging how much harder** it is for your child to get organized, stay on task, complete assignments, and learn material compared with other children. Help your child to get organized, break tasks down into smaller pieces, and expend his or her excess physical energy in ways that are "okay" at home and in the classroom.
- **Praising your child** and rewarding him or her for a job well done immediately after completing tasks or homework.
- **Joining a support group** for parents of children with ADHD or learning disabilities. Other parents may help you with ideas to help your child.

Another good way to get help from your school is to **determine if your school has a regular education process that helps teachers with students who are having learning or behavioral problems that the teacher has been unsuccessful in solving.** The process differs in various school districts and even among different schools in the same district. Some of the names this process may go by include Student Study Team (SST), Instructional Support Team (IST), Pupil Assistance Team (PAT), Student Intervention Team (SIT), or Teacher Assistance Team (TAT).

Parents are encouraged to request a meeting on their child to discuss concerns and create a plan of action to address their child's needs. In addition to the child's teacher, members of the team may include the child, the parents, a mentor teacher or other teachers, the principal, the school nurse, the resource specialist, a speech and language specialist, or a counselor or psychologist. The team members meet to discuss the child's strengths and weaknesses, the child's progress in his or her current placement, and the kinds of problems the child is having. The team members "brainstorm" to develop a plan of action that documents the kinds of interventions that will help the child, the timeline for the changes to take place, and the school staff responsible for the implementation of the team's recommendations.

The team should also come up with a plan to monitor the child's progress. A follow-up meeting should be scheduled within a reasonable time frame (usually 4 to 6 weeks) to determine whether the team's interventions are actually helping the child in the areas of difficulty.

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ADHD Coding Fact Sheet for Primary Care Clinicians

Current Procedural Terminology (CPT) Codes

Initial assessment usually involves time determining the differential diagnosis, a diagnostic plan, and potential treatment options. Therefore, most clinicians will report either an office/outpatient evaluation and management (E/M) code using time as the key factor* or a consultation code for the initial assessment.

Office or Other Outpatient E/M Codes

99201/99202/99203/99204/99205	Use for new† patients only; require 3 of 3 key components or greater than 50 percent of the visit spent in counseling or coordinating care.
99212/99213/99214/99215	Use for established patients; require 2 of 3 key components or greater than 50 percent of the visit spent in counseling or coordinating care.

Office or Other Outpatient Consultation Codes

99241/99242/99243/99244/99245	Use for new or established patients; appropriate to report if another physician or other appropriate source (ie, school nurse, psychologist) requests an opinion regarding a child potentially having ADHD. Require 3 of 3 key components or greater than 50 percent of the visit spent in counseling or coordinating care.

NOTE: Use of these codes *requires* the following:

- Written or verbal request for consultation is documented in the patient chart.
- Consultant's opinion as well as any services ordered or performed are documented in the patient chart.
- Consultant's opinion and any services that are performed are prepared in a *written* report, which is sent to the requesting physician or other appropriate source.

Prolonged Physician Services Codes

99354/99355	Use for *outpatient* face-to-face prolonged services.
99358/99359	Use for *non*–face-to-face prolonged services in any setting.

- Used when a physician provides prolonged services beyond the usual service (ie, beyond the typical time).
- An *alternate* to using time as the key factor with the office/outpatient E/M codes (99201–99215).
- Time spent does not have to be continuous.
- Codes are "add-on" codes, meaning they are reported separately in addition to the appropriate code for the service provided (eg, office or other outpatient E/M codes, 99201–99215).
- If the physician spends at least 30 and no more than 74 minutes more than the typical time associated with the reported E/M code, he or she can report 99354 (for face-to-face contact) or 99358 (for non–face-to-face contact). Codes 99355 (each additional 30 minutes of face-to-face prolonged service) and 99359 (each additional 30 minutes of non–face-to-face prolonged service) are used to report each additional 30 minutes of service beyond the first 74 minutes.
- Prolonged service of less than 15 minutes beyond the first hour or less then 15 minutes beyond the final 30 minutes is *not reported separately.*

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*Time can be used as the key factor in determining a level of service when counseling and/or coordinating care constitute more than 50% of the encounter.

†A new patient is defined as one who has not received any professional services from a physician, or another physician of the same specialty who belongs to the same group practice, within the past 3 years (*Principles of CPT Coding* [second edition], American Medical Association, 2001).

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ADHD Coding Fact Sheet for Primary Care Clinicians

Case Management Services Codes

99361/99362	Use to report a medical conference among the physician and an interdisciplinary team of health professionals to coordinate activities of patient care (patient not present).
99371/99372/99373	Use to report telephone calls made by the physician to patient or parent, for consultation or medical management, or for coordinating medical management with other health care professionals.

Central Nervous System Assessments/Tests Codes

96100	Use to report psychological testing, per hour; includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities (eg, WAIS-R, Rorschach test, MMPI).
96110	Use to report limited developmental testing with interpretation and report (eg, Developmental Screening Test II, Early Language Milestone Screen).
96115	Use to report neurobehavioral status examination with interpretation and report, per hour (eg, Conners Continuous Performance Test, Hawthorne Test).

Other Psychiatric Services or Procedures Codes

90862	Use to report pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (eg, Ritalin check).
90887	Use to report interpretation or explanation of results of psychiatric, other medical examinations or procedures, or other accumulated data to patient's family/guardian(s), or advising them how to assist patient.

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and *Diagnostic and Statistical Manual for Primary Care (DSM-PC)* Codes

- *Before ADHD is diagnosed,* do not use "rule out ADHD" as the diagnosis. Use as many diagnosis codes as apply to document the patient's complexity and report the patient's symptoms and/or adverse environmental circumstances.
- *Once a definitive ADHD diagnosis is established,* report the appropriate definitive diagnosis code(s) as the primary code, plus any other symptoms that the patient is exhibiting as secondary diagnoses.
- Counseling diagnosis codes can be used when the patient is present or when counseling the parent/guardian(s) when the patient is not physically present.

ICD-9-CM Codes

293.84	Organic anxiety syndrome
300.00	Anxiety state, unspecified
300.01	Panic disorder
300.02	Generalized anxiety disorder
300.20	Phobia, unspecified
300.23	Social phobia
300.29	Other isolated or simple phobia
300.4	Neurotic depression
307.0	Stammering and stuttering
307.9	Other and unspecified special symptoms or syndromes, not elsewhere classified (NEC)
309.21	Separation anxiety disorder
309.3	Adjustment reaction; with predominant disturbance of conduct
312.00	Undersocialized conduct disorder, aggressive type; unspecified
312.30	Impulse control disorder, unspecified
312.81	Conduct disorder, childhood onset type
312.82	Conduct disorder, adolescent onset type
312.9	Unspecified disturbance of conduct
313.81	Oppositional disorder
313.83	Academic underachievement disorder
314.00	Attention-deficit disorder, without mention of hyperactivity
314.01	Attention-deficit disorder, with mention of hyperactivity
314.1	Hyperkinesis with developmental delay
314.2	Hyperkinetic conduct disorder
314.8	Other specified manifestations of hyperkinetic syndrome
314.9	Unspecified hyperkinetic syndrome
315.00	Reading disorder, unspecified
315.01	Alexia
315.02	Developmental dyslexia
315.09	Specific reading disorder; other
315.1	Specific arithmetical disorder
315.2	Other specific learning difficulties
315.31	Developmental language disorder
315.32	Receptive language disorder (mixed)
315.39	Developmental speech or language disorder; other
315.4	Coordination disorder
315.5	Mixed developmental disorder
315.8	Other specified delay in development
315.9	Unspecified delay in development
781.3	Lack of coordination

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ICD-9-CM Codes, continued

NOTE: The *ICD-9-CM* codes below are used to deal with occasions when circumstances other than a disease or injury are recorded as "diagnoses" or "problems." Some carriers may request supporting documentation for the reporting of V codes.

V40.0 Problems with learning
V40.1 Problems with communication (including speech)
V40.3 Mental and behavorial problems; other behavioral problems
V40.9 Unspecified mental or behavioral problem
V60.0 Lack of housing
V60.1 Inadequate housing
V60.2 Inadequate material resources
V60.8 Other specified housing or economic circumstances
V61.20 Counseling for parent-child problem, unspecified
V61.29 Parent-child problems; other
V61.49 Health problems with family; other
V61.8 Health problems within family; other specified family circumstances
V61.9 Health problems within family; unspecified family circumstances
V62.0 Other psychosocial circumstances; unemployment
V62.5 Other psychosocial circumstances; legal circumstances
V62.81 Interpersonal problems, NEC
V62.82 Bereavement, uncomplicated
V62.89 Other psychological or physical stress, NEC; other
V62.9 Unspecified psychosocial circumstance
V65.49 Other specified counseling
V71.02 Observation for suspected mental condition; childhood or adolescent antisocial behavior

DSM-PC Codes

300.01 Panic disorder
300.02 Generalized anxiety disorder
300.23 Social phobia
300.29 Specific phobia
307.0 Stuttering
307.9 Communication disorder, not otherwise specified (NOS)
308.3 Acute stress disorder
309.21 Separation anxiety disorder
309.3 Adjustment disorder with disturbance of conduct
309.81 Posttraumatic stress disorder
312.81 Conduct disorder, childhood onset
312.82 Conduct disorder, adolescent onset
312.9 Disruptive behavior disorder, NOS
313.81 Oppositional-defiant disorder
314.00 Predominantly Inattentive type
314.01 Predominantly Hyperactive-Impulsive type
314.01 Combined type
314.9 Attention-deficit/hyperactivity disorder, NOS
315.0 Reading disorder (developmental reading disorder)
315.1 Mathematics disorder (developmental arithmetic disorder)
315.2 Disorder of written expression (developmental expressive disorder)
315.31 Expressive language disorder
315.32 Mixed receptive-expressive language disorder
315.39 Phonologic disorder
315.4 Developmental coordination disorder
315.9 Learning disorder, NOS
781.3 Developmental coordination problem
V40.0 Learning problem
V40.1 Speech and language problem
V40.2 Anxiety problem
V40.3 Hyperactive/impulsive behavior problem
V40.3 Inattention problem
V40.3 Sadness problem
V62.3 Developmental/cognitive problem
V62.82 Bereavement
V65.4 Aggressive/oppositional variation
V65.4 Developmental/cognitive variation
V65.49 Aggressive/oppositional variation
V65.49 Anxious variation
V65.49 Developmental coordination variation
V65.49 Hyperactive/impulsive variation
V65.49 Inattention variation
V65.49 Learning variation
V65.49 Negative emotional behavior variation
V65.49 Sadness variation
V65.49 Secretive antisocial behaviors variation
V65.49 Speech and language variation
V71.02 Aggressive/oppositional problem
V71.02 Negative emotional behavior problem
V71.02 Secretive antisocial behaviors problem

ADHD Encounter Form

Today's Date: _____ Child's Name: _____ Age: _____

Sex: ☐ Male ☐ Female BD: _____ MR#: _____ Parent Name(s): _____

***CPT* Procedure Codes (Circle the codes that apply.)**

Evaluation and Management (E/M)					
Office Consultations	**New or Established Patients**	**Office Visits**	**New Patients**	**Office Visits**	**Established Patients**
Focused	99241	Focused	99201	Minimal	99211
Expanded	99242	Expanded	99202	Focused	99212
Detailed	99243	Detailed	99203	Expanded	99213
Moderately complex	99244	Moderately complex	99204	Detailed/Moderately complex	99214
Highly complex	99245	Highly complex	99205	Highly complex	99215
Prolonged Face-to-Face Services	**(Report in addition to E/M code.)**				
Prolonged face-to-face service; first hour	99354	Prolonged face-to-face service; each additional half hour	99355		

Other Services				
Psychological testing, per hour 96100	Developmental testing; limited, per hour 96110	Developmental testing; extended, per hour 96111	Neurobehavioral status exam, per hour 96115	Individual psychotherapy (20-30 minutes) 90804
Individual psychotherapy (45-50 minutes) 90806	Group psychotherapy 90853	Family psychotherapy 90846 or 90847	Team conference (30 minutes) 99361	Team conference (60 minutes) 99362
Telephone consult 99371, 99372, or 99373	Home visit 99341-50	Group counseling with symptoms 99078		

***ICD-9-CM* Diagnosis Codes (Circle all codes that apply.)**

ADHD and Counseling

Condition	***ICD-9-CM***	**Condition**	***ICD-9-CM***	**Condition**	***ICD-9-CM***	**Condition**	***ICD-9-CM***
ADD w/out mention of hyperactivity	314.00	ADD with hyperactivity	314.01	Hyperkinesis w/ developmental delay	314.1	Hyperkinetic conduct disorder	314.2
Other specified manifestations of hyperkinetic syndrome	314.8	Unspecified hyperkinetic syndrome	314.9	Other specified counseling	V65.49	Mental and behavioral problems; other behavioral problems	V40.3

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Adverse Environmental Circumstances							
Condition	***ICD-9-CM***	**Condition**	***ICD-9-CM***	**Condition**	***ICD-9-CM***	**Condition**	***ICD-9-CM***
Lack of housing	V60.0	Inadequate	V60.1	Inadequate material	V60.2	Other specified housing or economic circumstances	V60.8
Counseling for parent-child problem, unspecified	V61.20	Parent-child problems; other	V61.29	Counseling for marital and partner problems, unspecified	V61.10	Health problems within family; other	V61.49
Health problems within family; other specified family circumstances	V61.8	Health problems within family; unspecified family circumstances	V61.9	Other psychosocial circumstances; unemployment	V62.0	Other psychosocial circumstances; legal circumstances	V62.5
Interpersonal problems, not elsewhere classified (NEC)	V62.81	Bereavement, uncomplicated	V62.82	Other psychological or physical stress, NEC; other	V62.89	Unspecified psycho-social circumstance	V62.9
Child neglect (nutritional)	995.52	Child sexual abuse	995.53	Child physical abuse	995.54	Perpetrator of child and adult abuse	E967.0–E967.9
Anxiety and Depression							
Organic anxiety syndrome	293.84	Major depressive disorder, single episode, unspecified	296.20	Major depressive disorder, single episode, mild	296.21	Major depressive disorder, single episode, moderate	296.22
Major depressive disorder, single episode, severe, without mention of psychotic behavior	296.23	Major depressive disorder, recurrent episode, unspecified	296.30	Major depressive disorder, recurrent episode, mild	296.31	Major depressive disorder, recurrent episode, moderate	296.32
Major depressive disorder, recurrent episode, severe, without mention of psychotic behavior	296.33	Anxiety state, unspecified	300.00	Panic disorder	300.01	Generalized anxiety disorder	300.02
Anxiety state; other	300.09	Phobia, unspecified	300.20	Social phobia	300.23	Other isolated or simple phobia	300.29
Neurotic depression	300.4	Separation anxiety disorder	309.21				
Externalizing or Disruptive Disorder: Conduct Problems, Oppositional Behavior, Aggression							
Nondependent abuse of drugs	305.00–305.93	Adjustment reaction; with predominant disturbance of conduct	309.3	Other specified disturbances of conduct, NEC; conduct disorder, childhood onset type	312.81	Other specified disturbances of conduct, NEC; conduct disorder, adolescent onset type	312.82
Unspecified disturbance of conduct	312.9	Oppositional disorder	313.81	Other specified counseling	V65.49	Observation for suspected mental condition; childhood or adolescent antisocial behavior	V71.02

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Learning Disorders and Disabilities							
Condition	**ICD-9-CM**	**Condition**	**ICD-9-CM**	**Condition**	**ICD-9-CM**	**Condition**	**ICD-9-CM**
Stammering and stuttering	307.0	Other and unspecified special symptoms or syndromes, NEC	307.9	Reading disorder, unspecified	315.00	Specific arithmetical disorder	315.1
Other specific learning difficulties	315.2	Developmental language disorder	315.31	Receptive language disorder (mixed)	315.32	Developmental speech or language disorder; other	315.39
Coordination disorder	315.4	Unspecified delay in development	315.9	Mild mental retardation	317	Moderate mental retardation	318.0
Severe mental retardation	318.1	Profound mental retardation	318.2	Unspecified mental retardation	319	Lack of coordination	781.3
Mental and behavioral problems; problems with learning	V40.0	Mental and behavioral problems; problems with communication (including speech)	V40.1	Other psychosocial circumstances; educational circumstances	V62.3		
Other Diagnoses							
Infantile autism, current or active state	299.00	Other specified early childhood psychoses, current or active state	299.80	Tic disorder, unspecified	307.20	Transient tic disorder of childhood	307.21
Gilles de la Tourette disorder	307.23	Stereotyped repetitive movements	307.3				

Physician's Signature_____ Date _____

ADHD *DSM-IV* Coexisting Conditions

Circle all criteria in each section that apply, then check boxes for diagnosis.

INTERNALIZING DISORDERS

Generalized Anxiety Disorder — ***DSM-IV* 300.02**

Excessive and persistent worries ≥6 months duration affecting multiple activities and events and manifest if 3 of 6:

1. Restlessness, feeling keyed up, on edge
2. Being easily fatigued
3. Difficulty concentrating, mind going blank
4. Irritability
5. Muscle tension
6. Sleep disturbance

Major Depressive Disorder — ***DSM-IV* 296.20–296.36**

≥5 of 9 criteria almost every day for 2 weeks with at least depressed mood or loss of interest or pleasure:

1. Depressed mood or irritable by subjective report or observation
2. Markedly diminished interest or pleasure in all or almost all activities
3. Weight loss/gain without dieting
4. Insomnia or hypersomnia almost every day
5. Psychomotor agitation or retardation
6. Fatigue or energy loss
7. Feelings of worthlessness or excessive guilt
8. Diminished ability to think or concentrate
9. Recurrent thoughts of death or suicide

Other Anxiety Disorders

- Other isolated or specific phobia — *DSM-IV* 300.29
- Separation anxiety disorder — *DSM-IV* 309.21
- Anxiety state, unspecified — *DSM-IV* 300.00

Other Depression Disorders

- Neurotic depression — *DSM-IV* 300.4
- Brief depressive reaction — *DSM-IV* 309.0
- Depressive disorder, NEC — *DSM-IV* 311
- Bereavement, uncomplicated — *DSM-IV* V62.82

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EXTERNALIZING DISORDERS

Oppositional Defiant Disorder — *DSM-IV* 313.81

A pattern of negative, hostile, defiant behavior for ≥6 months causing impairment and ≥4 of 8:

1. Often loses temper
2. Often argues with adults
3. Often defies or refuses to comply
4. Often deliberately annoys people
5. Often blames others for mistakes, misbehavior
6. Is often touchy or easily annoyed
7. Is often angry and resentful
8. Is often spiteful

Other Disorders

Adjustment reaction; with predominant disturbance of conduct	*DSM-IV* 309.3

Other Specified Disturbances of Conduct, NEC — *DSM-IV* 312.8

A repetitive and persistent pattern in which the basic rights of others and norms are violated with 3 criteria in past 12 months, 1 in past 6 months:

Aggression to people and animals

1. Often bullies, threatens, or intimidates others
2. Often initiates physical fights
3. Has used a weapon that can cause serious harm (bat, brick, broken bottle, knife, gun)
4. Has been physically cruel to people
5. Has been physically cruel to animals
6. Has stolen while confronting a victim (mugging, extortion, armed robbery)
7. Has forced someone into sexual activity

Destruction of property

8. Has deliberately engaged in fire setting
9. Has deliberately destroyed other's property

Deceitfulness or theft

10. Has broken into someone's house, car
11. Often lies to obtain goods or favors
12. Has stolen

Serious violation of the rules

13. Stays out despite parental prohibition
14. Has run away overnight more than once
15. Is often truant

Other Disorders

Intermittent explosive disorder	*DSM-IV* 312.34
Adjustment reaction; with mixed disturbance of emotions and conduct	*DSM-IV* 309.4

MENTAL RETARDATION OR LEARNING DISABILITIES

Mental Retardation

Mild mental retardation	*DSM-IV* 317	Profound mental retardation	*DSM-IV* 318.2
Moderate mental retardation	*DSM-IV* 318.0	Unspecified mental retardation	*DSM-IV* 319
Severe mental retardation	*DSM-IV* 318.1		

Learning Disabilities or Problems

Reading disorder, unspecified	*DSM-IV* 315.00	Other developmental or language disorder	*DSM-IV* 315.39
Specific arithmetical disorder	*DSM-IV* 315.1	Developmental language disorder	*DSM-IV* 315.31
Other specific learning difficulties	*DSM-IV* 315.2	Receptive language disorder (mixed)	*DSM-IV* 315.32
Unspecified delay in development	*DSM-IV* 315.9	Other and unspecified special symptoms or syndromes, NEC	*DSM-IV* 307.9
Coordination disorder	*DSM-IV* 315.4	Stammering and stuttering	*DSM-IV* 307.0

OTHER		OTHER (Specify)
Infantile autism, current or active state	*DSM-IV* 299.00	
Gilles de la Tourette disorder	*DSM-IV* 307.23	
Stereotyped repetitive movements	*DSM-IV* 307.3	

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Documentation for Reimbursement

Date _____

Attn: Case Manager
Insurance Company _____

Re: [Name of child or adolescent; dob]

To whom it may concern,

I saw [name of child or adolescent] on [visit date] for [diagnosis].

This letter documents the components of the services provided and billed with the diagnosis code of _____ .

The following services were provided:

_____ Parent conference regarding the diagnosis, etiology, management, and medical treatments of [diagnosis name]. This conference lasted approximately_____ minutes.

_____ Face-to-face visit with child or adolescent for additional discussion and initiation of therapy. This visit lasted approximately _____ minutes.

_____ Correspondence to the school [name of child or adolescent] attends.

_____ Review of school records.

_____ Phone consultation(s). These consultations lasted a total of approximately _____ minutes.

_____ Other:_____

_____

_____

Should you have any additional questions or wish these services to be coded in a different way, please contact _____ in my office.

Thank you for your consideration.

Sincerely,
[Name of health professional]

From Hagan JF Jr. Documentation for reimbursement. In: Jellinek M, Patel BP, Froehle MC, eds. *Bright Futures in Practice: Mental Health—Volume II. Tool Kit*. Arlington, VA: National Center for Education in Maternal and Child Health; 2002. Used with permission.

ADHD Resources Available on the Internet

ADHD Information

About Our Kids
http://www.aboutourkids.org/articles/about_adhd.html

ADDitude Magazine for People With ADHD
http://www.additudemag.com

ADDvance Online Resource for Women and Girls With ADHD
http://www.addvance.com

American Academy of Family Physicians (AAFP)
http://www.aafp.org

American Academy of Pediatrics (AAP)
http://www.aap.org

American Medical Association (AMA)
http://www.ama-assn.org

Attention-Deficit Disorder Association (ADDA)
http://www.add.org

Attention Research Update Newsletter
http://www.helpforadd.com

Bright Futures
http://www.brightfutures.org

Center for Mental Health Services Knowledge Exchange Network
http://www.mentalhealth.org

Children and Adults With Attention-Deficit/Hyperactivity Disorder (CHADD)
http://www.chadd.org

Comprehensive Treatment for Attention-Deficit Disorder (CTADD)
http://www.ctadd.com

Curry School of Education (University of Virginia) ADD Resources
http://teis.virginia.edu/go/cise/ose/categories/add.html

Intermountain Health Care
http://www.ihc.com/xp/ihc/physician/clinicalprograms/primarycare/adhd.xml

National Center for Complementary and Alternative Medicine (NCCAM)
http://nccam.nih.gov

National Institute of Mental Health (NIMH)
http://www.nimh.nih.gov/publicat/adhdmenu.cfm

Northern County Psychiatric Associates
http://www.ncpamd.com/adhd.htm

One ADD Place
http://www.oneaddplace.com

Pediatric Development and Behavior
http://www.dbpeds.org

San Diego ADHD Web Page
http://www.sandiegoadhd.com

Vanderbilt Child Development Center
http://peds.mc.vanderbilt.edu/cdc/rating~1.html

Educational Resources

American Association of People With Disabilities (AAPD)
http://www.aapd.com

Consortium for Citizens With Disabilities
http://www.c-c-d.org

Council for Learning Disabilities
http://www.cldinternational.org

Education Resources Information Center (ERIC)
http://ericir.syr.edu

Federal Resource Center for Special Education
http://www.dssc.org/frc

Internet Resource for Special Children
http://www.irsc.org

Learning Disabilities Association of America
http://www.ldanatl.org

National Information Center for Children and Youth With Disabilities (NICHCY)
http://www.nichcy.org

Parent Advocacy Coalition for Educational Rights (PACER) Center
http://www.pacer.org

SAMSHSA
http://www.disabilitydirect.gov

SandraRief.com
http://sandrarief.com

TeachingLD
http://www.dldcec.org

US Department of Education
http://www.ed.gov

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