JCMC
Promoting a Healthier Future

ADHD CONSULTATION GUIDELINES

Forms Completed On: ____ / ____ / ____

PATIENT NAME: *First:* *Last:*

DATE OF BIRTH: ____ / ____ / ____

Dear Parents,

All forms must be completed prior to your child's scheduled ADHD consultation and brought to the child's appointment.

- JCMC ADHD Guidelines
- Venderbilt Assessment scale for parents
- Vanderbllt Assessment scale for teachers- Please let us know if your child has more than one teacher so we may provide you with extra teacher Vanderbilt forms.
- Controlled Medication Use Agreement for Children
- Generalized Anxiety Disorder Scale
- Past Medical Information
- Consent to treat
- Authorization for Release of Information
- Financial Policy
- Notice of Privacy Practices

If your child has a previous diagnosis of ADHD please bring that documentation to the appointment as well.

Please review the following guidelines on what to expect when a child Is diagnosed and treated for ADHD at JCMC.

1. Your child's weight, blood pressure and height will be measured at every visit to assist in monitoring medication side effects.
2. **Medication Management Policy:** Prescriptions for controlled substances are provided in accordance with the North Carolina Medical Board (NCMB) guidelines.
   - Patients who are stable and doing well on their current medication will need to follow up with their provider every 60–90 days. Patients who are still adjusting medications or whose symptoms are not yet stable will need a follow-up appointment within 28 days after any medication changes.
   - To ensure uninterrupted care, please plan to schedule your next appointment before leaving the office after each visit.
3. Patients who do not show up for appointments will not be provided with a refill of their controlled medication prescriptions.
4. The primary care giver/parent should be present at all appointments.
5. All patients—or their parent or legal guardian, when applicable—are required to review and sign the JCMC Controlled Medication Use Agreement before controlled medications can be prescribed or managed.

PRINT NAME OF PERSON PICKING UP ADHD PACKET _____

SIGNATURE OF PERSON PICKING UP ADHD PACKET _____

DATE: ____ / ____ / ____

144 Memorial Court
Jacksonville, NC 28546

Phone: 910-353-0581
Fax: 910-219-1484

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Jacksonville Children's and Multispecialty Clinic, P.A.

PAST HISTORY AND INFORMATION SHEET

PATIENT NAME: *First:* *Last:*

DATE OF BIRTH: / /

DIRECTIONS: Please answer these questions as completely as possible prior to attending your first session with your provider. Your responses will help us learn about your circumstances and assist you with individualized treatment for your concerns.

PLEASE NOTE: Legal guardian/parent must sign enclosed consent form

PRESENTING PROBLEM:
Please (**circle)** all the areas that are a major difficulty for your child.

Emotional Problems: Depression Anxiety Low Self-esteem Suicidal thoughts

Behavioral Problems: Aggression Tantrums Lying Oppositional Hyperactivity
Destructiveness Stealing Drug/Alcohol Use Cruel to animals
Sets fires Friendship Problems Family Conflict Abuse

School Problems: Learning Problems Poor Attention Span Truancy School Refusal

Medical Health Problems: Eating Problems Sleep Problems Soiling/Wetting

Other Problems: Development Delay Other (Describe): _____

FAMILY HISTORY: If yes, indicate who (e.g., mother, father, sibling). ADHD Depression Anxiety
Bipolar Learning Disability Other Mental Health/Behavioral

PLEASE LIST ANY OF OTHER EVALUATIONS THAT YOUR CHILD HAS RECEIVED FOR THIS PROBLEM:

EVALUATED BY: **DATE:** / /

LOCATIONS:

RESULTS:

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INFORMED CONSENT & CONTROLLED MEDICATION USE AGREEMENT

PATIENT NAME: *First:* *Last:*

DATE OF BIRTH: / /

I understand that I or my dependent child has a condition(s) whose treatment may require the use of controlled substances including opioid pain medications, controlled stimulants, or anti-anxiety medications as defined by the North Carolina Medical Board. After carefully discussing risks, benefits and alternatives with my provider, I wish to be treated for this condition with controlled medications as prescribed below:

Medication/Strength	*Dosage/Quantity*	*Refill Schedule*

The Patient agrees to and accepts the following conditions. Failure to comply with the conditions in this agreement may result in these medications being discontinued and possible termination of the prescriber/patient relationship.

1. New patients requesting prescriptions for controlled substances as continuing care will be required to provide records from their previous provider documenting their treatment history.

2. I will take or allow my dependent child to take the medication only as prescribed by my JCMC provider(s). I will not change how these medicines are taken without prior specific permission from my prescribing provider. I will not take or give to my dependent child any sedatives, alcohol or other controlled medications without the prior approval of my provider. I will not take or permit my dependent child to take any other medications including those borrowed or accepted from friends or family members or any illicit or street drugs.

3. If other providers prescribe controlled medication(s) for me or my dependent child for other conditions, I will inform them of this agreement before they prescribe for me and I will promptly notify the provider who created this agreement with me of the new medication(s).

4. I will have all prescriptions for controlled medication(s) filled only at the following pharmacy:

5. In the event that I must use another pharmacy to fill my prescription, I will notify my provider as soon as possible.
6. I authorize my provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the North Carolina Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled medicine. I authorize my provider to provide a copy of this agreement to my pharmacy. I agree to wave any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

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INFORMED CONSENT & CONTROLLED MEDICATION USE AGREEMENT

- I authorize my provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the North Carolina Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of the controlled medicine. I authorize my provider to provide a copy of this agreement to my pharmacy. I agree to wave any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- I understand that Jacksonville Children's and Multispecialty Clinic participates in North Carolina Controlled Substances Registry. Patient prescription history will be reviewed, and any discrepancies may result in dismissal from the practice.
- Refills will be given only during office hours with three business days' advance notice. If my child's-controlled medication(s) is/are lost, misplaced, or stolen or if they finish them earlier than prescribed, they will not be replaced
- My child and I will meet regularly with the provider or practice providers for scheduled appointments. I understand that my failure to make and keep these appointments may prevent my child's medications) being filled.
- I understand that my child's provider may require specialist evaluation of the condition and treatment. I agree to keep those appointments when the provider refers my child New patients who are referred to psychiatry will have three months to establish care with the specialist.
- Success in treatment is measured by my child's ability to function. Evidence of improved functioning is a requirement for continued treatment. I understand that the provider may change or discontinue a medication if there is no longer evidence that my child is receiving reasonable therapeutic benefit from the medication or that they are no longer a good candidate to continue the medications).
- I agree to taper my child's dose of the controlled medications) to determine their effectiveness on request of my provider.
- If my child is unable to tolerate any controlled medication(s), or if I wish to request changes in dosage or medication(s), I agree to properly dispose of the medications per Regulatory guidelines
- I agree for my child to have a blood or urine test for drug analysis at any time it is requested by my child's provider. Random drug and alcohol screens are for my child's protection, I understand that use of alcohol or recreational drugs or failure to comply with the requested blood or urine testing may result in denial of further prescription for controlled medications).
- I agree that I will not give, sell or in anyway distribute prescribed medications to other person(s).
- I agree I will not in any way attempt to forge or alter a prescription.
- I agree that I will not verbally abuse clinic staff.

If I deviate from the above agreement, I understand that the controlled medication(s) may be tapered and not re-prescribed and may result in my or my child's dismissal as a patient from Jacksonville Children's and Multispecialty Clinic.

This controlled medication agreement replaces and invalidates all previous controlled medication agreements made for this chronic condition. I understand that by signing this agreement, I must abide by the rules above which are for my child's protection and safety, and that failure to abide by this agreement will result in the termination of medication prescriptions and possibly the termination of all services from my provider and his or her practice.

Patient (or Parent/Guardian) Signature	*Provider Signature*
Date	*Date*

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CONSENT TO TREAT

PATIENT NAME: *First:* *Last:*

DATE OF BIRTH: / /

I affirm that I, , am the **(Check one below)**

☐ PATIENT ☐ PARENT ☐ LEGAL GUARDIAN

and responsible party hereby acknowledge that I authorize and give permission to the staff of **Jacksonville Children's and Multispecialty Clinic (JCMC**) to render treatment and/or services to myself/patient named on page 1 of the Health History Form. 'understand that I can withdraw this consent t treatment at any time. A withdrawal of consent must be done in writing and will include the reason for withdrawal. I understand the practice of medicine, psychiatry and other mental health disciplines is not an exact science and I acknowledge that no guarantees have been made to me concerning care. Because psychotherapy (counseling) is a cooperative effort between patient and therapist, I will not hold JCMC or any individual responsible for any consequences resulting from my decision beyond that time. I understand that state and local laws required that my psychiatrist/psychologist/therapist to report all cases in which there exists a specific potential harm to others in cases of reported or suspected physical, sexual and/or neglect of children which are required by law. JCMC'S treatment is for medical purposes only and not suitable for forensic purposes.

Electronic Devices and Cell Phones: The use of ANY electronic device used for taking pictures or recordings is prohibited in this facility by Patient Privacy Rules. We also prohibit cell phone conversations in our waiting room. You will be asked to continue your phone call outside; this is to protect your privacy as well those in our waiting room. Failure to follow these rules may result in your appointment being canceled and/or may result in termination from the practice.

Illness: If you have an illness or are exhibiting symptoms, we recommend you cancel and reschedule your appointment.

NO-SHOW POLICY

We require a 24 hour notice of cancellation for if appointments. Failure to cancel your appointment without a 24 hour notice will result in your account being billed a **$25 NO SHOW FEE**. Patients that no show two times will receive a warning letter. Patients that no show three times or more will be considered by your provider for the possibility of being discharged from this practice. Your provider will either request another warning letter be sent to the patient or the patient will receive a letter discharging the patient from your provider's service. No Show count will be within one year timeframe.

SIGNATURE OF PATIENT / PARENT / LEGAL GUARDIAN: *Date:*

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GENERALIZED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE

PATIENT NAME: *First:* *Last:*

DATE OF BIRTH: / / **DATE OF SERVICE:** / /

OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY THE FOLLOWING PROBLEMS?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

If you checked off **any** problems, how **difficult** have these made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. Arch Inern Med. 2006;166:1092-1097.

NICHQ Vanderbilt Assessment Scale—PARENT Informant 7/10

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.

Revised - 1102

American Academy of Pediatrics

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NICHQ National Institute for Children's Health Quality

McNeil Consumer & Specialty Pharmaceuticals

V1.2 Effective Date: 8/27/26

NICHQ Vanderbilt Assessment Scale—PARENT Informant 8/10

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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V1.2 Effective Date: 8/27/26

D4 **NICHQ Vanderbilt Assessment Scale—TEACHER Informant** **9/10**

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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11-20/rev0303

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