

This file contains the *CAPSS Baseline Notification Questionnaire* from the NIHR CATCH-uS ADHD Transition Research Project (2015 – 2019).

For more information or to ask permission to use this tool please contact catchus@exeter.ac.uk



**Case notification form Questionnaire –
Strictly Confidential**

CATCh-uS (Children with ADHD in transition between children’s and adult services)

The first page of the case notification form will be stored separately from the rest of the questionnaire and personal identifying information for the case (young person) will be used only for linkage of records.

Reporting Instructions:

Please report any young person with ADHD taking medication for ADHD seen by you for the first time in the six months preceding the young person reaching your service’s age boundary. Please report any case even if you believe the case may have been reported from elsewhere.

Case Definition:

Section A: Reporter Details

- 1.1 Date of completion of questionnaire:
- 1.2 Consultant or specialist responsible for case: _____
- 1.3 Name of clinic and Trust/Provider: _____
- 1.4 Telephone number: _____ Email: _____

Section B: Case Details

- 2.1 NHS/CHI No:
- 2.2 Hospital No:
- 2.3 First half of postcode only Town of Birth (if ROI) _____
- 2.4 Sex: M F Age of young person (Years/months) _____
- 2.5 Ethnicity*: Specify if any “Other” background: ___

**Please choose the correct ethnicity code from Appendix A overleaf*

Appendix A

Appendix A: Coding for Ethnic Group (ONS 2011 for UK wide data collection)

	Ethnicity Code		Ethnicity Code
A White			
English / Welsh / Scottish / Northern Irish / British	1	D Black / African / Caribbean / Black British	
Irish	2	African	14
Gypsy or Irish Traveller	3	Caribbean	15
Any other White background, please describe	4	Any other Black / African / Caribbean background, please describe	16
Mixed/ Multiple Ethnic Groups			
B Groups			
White and Black Caribbean	5	E Other ethnic group	
White and Black African	6	Arab	17
White and Asian	7	Any other ethnic group, please describe	18
Any other Mixed / Multiple ethnic background, please describe	8		
C Asian / Asian British			
Indian	9		
Pakistani	10		
Bangladeshi	11		
Chinese	12		
Any other Asian background, please describe	13		

Section C: Eligibility of case

3.1 Does the young person meet the following criteria for this study?

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Does the young person have a clinical diagnosis of ADHD? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is the young person currently receiving drug treatment for their ADHD? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does the young person require continuation of their drug treatment <u>for their ADHD</u> after transition from your service (i.e. in adult services)?
<i>Note: please ONLY tick 'yes' if this drug treatment is required for their ADHD rather than any existing comorbid diagnosis.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is the young person within six months of the age boundary for your service? i.e. in ideal circumstances, within six months of transition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is this the first time this patient is being reported to this study by your service?
<i>Note: Please only report a case once - those who have already been seen and reported by you in this time-scale should not be reported a second time.</i> | <input type="checkbox"/> | <input type="checkbox"/> |

3.2 Does this young person meet all of the five criteria (yes to all questions) Yes No

- If so, please continue with the questionnaire.
- If not, thank you again for your time. There are no further questions to answer; please proceed on page 6 of this questionnaire.

Section D: Comorbidities and medication

4.1 Aside from their clinical diagnosis of ADHD, does this young person have any other mental health or developmental diagnoses?

- Yes
 No
 Not known to me

Please list any other diagnoses below:

- | | |
|--|---|
| <input type="checkbox"/> Autism spectrum condition | <input type="checkbox"/> Dyspraxia |
| <input type="checkbox"/> Chronic Tic disorder / Tourette's | <input type="checkbox"/> Problematic substance abuse |
| <input type="checkbox"/> ODD / Conduct disorder | <input type="checkbox"/> Other? Please specify: |
| <input type="checkbox"/> Anxiety disorder | |

4.2 Please list below the medication which the young person is currently prescribed for any mental health / developmental conditions and the indication. Please also indicate whether you consider that this medication requires continuation beyond the age boundary for your service.

Medication and indication	Requires continuation		
	Yes	No	Don't know
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section E: Referral of the case

5.1 What is the age boundary for your service?

__ years __ months

5.2 What is the current status of this case regarding reaching the age boundary of your service?

I last saw the young person __/__/____

Has the young person already reached the age boundary for your service? Yes No

Do you have another appointment with the young person? Yes No

Are you still responsible for the young person? Yes No

5.3 Have you started the transition process for this young person yet?

- Yes – Please continue this questionnaire.
- No – Please go to page 6 of the questionnaire.

5.4 What is the intended destination for this young person following transfer from your service, for the management of their ADHD? Please provide name and or contact details of the service.

- Specialist Adult ADHD service: _____
- Other Adult Mental Health Service: _____
- Primary care / GP: _____
- No specific arrangements are made
- Other. Please give details or any other comments below:
-

Section F: The transition protocols and procedures

6.1 Does your organisation have a transition protocol?

Yes No

6.2 Are you using it to plan the transition for this young person?

Yes No

Section G: Facts regarding the transition of the young person

7.1 Key stages in the transition process: which of the following steps have you undertaken? Please give an indication of time if you have engaged in this element of the transition process (DD/MM/YYYY).

When did you first discuss a transfer to an adult service with your patient?

Date: _____ Not yet Not known to me

When did you first refer the young person to an adult service?

Date: _____ Not yet Not known to me

How many services did you approach to find a match for your client?

Just one More than one: _____

If a referral was made, was the referral accepted?

Yes, Date: _____ No I am awaiting a response

7.2 Partners involved: State which of the following partners are involved in the transition process:

	Yes	No	Not known
Young person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care co-ordinator from adult team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care co-ordinator from child team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other? Please specify: _____			

7.3 Which of the following elements of the transition process have been initiated:

	Yes	No	Not known
Information sharing between services (case notes or summaries)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Young person's involvement in decision making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organising a transition planning meeting (involving the young person and carer, and key professionals of both services)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning and agreeing on a care plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A period of handover or parallel/joint care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other elements you want to add:			

Section H: Request to take part in follow-up

- 8.1** We wish to interview a sample of clinicians about their general experiences of managing transition, using a semi-structured telephone interview that will take approximately 30 minutes. Would you be willing to be contacted regarding taking part in such an interview? (This does not constitute any obligation to take part). We will not be discussing individual cases.

Yes

No

Thank you for taking the time to complete the questionnaire

Please print and return the completed form in the SAE to:

Prof Dr Tamsin Ford

██
██
██
██

If you have any questions about the study please do not hesitate to contact the investigators by email or telephone : Prof Tamsin Ford

Telephone: ██ Email: ██

Ethical approval

This study has been approved by NRES South Yorkshire Ethics Committee – Yorkshire & The Humber (REC Reference: 15/YH/0426) and has been granted **Section 251 HRA-CAG permission (CAG Reference: 15/CAG/0184)**.