Shared Care Guideline
The prescribing of Methylphenidate, Dexamfetamine, Lisdexamfetamine Atomoxetine and Guanfacine for the treatment of Attention Deficit Hyperactivity Disorder in Children and Young People

Executive Summary

This guideline covers the use of methylphenidate, dexamfetamine, lisdexamfetamine atomoxetine and guanfacine for children and young people with Attention Deficit Hyperactivity Disorder (ADHD), in line with NICE Guideline NG87.

The GP is expected to:

- Prescribe the recommended medication after initiation and stabilisation by the specialist (also, in exceptional clinical circumstances prescribing by the GP may be requested during titration; the GP may agree to do so on these occasions providing clear guidance has been given by the specialist)
- Monitor height, weight, blood pressure and pulse at six months annually in between the annual specialist reviews. Fax or email these findings to the clinic for action by the specialist service.
- Check for drug interactions and contraindications when prescribing other medicines
- Act in accordance with the advice in this guideline if side effects are identified

The specialist is expected to:

- Undertake an assessment and identify people suitable for medication
- Initiate prescribing and ask for transfer to shared care when stable
- Assess for efficacy and adverse effects at the start of treatment and then at least yearly, monitoring height, weight, pulse and blood pressure at annual reviews. More frequent monitoring is needed for guanfacine in the first year.
- Respond to blood pressure, pulse, height and weights sent in by GPs with advice about continuing (or not) the ADHD medication.
- Arrange transfer of care over the age of 17

The parent / guardian is expected to:

- Follow the specialist's advice by booking an appointment for their child's blood pressure, pulse, weight and height to be measured, attending these and specialist appointments.
- Let the prescribers know if there are any concerns
- Store the tablets safely out of the reach of children and young people

Sharing of care depends on communication between the specialist, GP and the patient or their parent/carer. The intention to share care should be explained to the patient and accepted by them. Patients are under regular follow-up and this provides an opportunity to discuss drug therapy. The doctor/healthcare professional who prescribes the medication has the clinical responsibility for the drug and the consequences of its use.

1. Scope

Children and adolescents (from 6 years old to their 17th birthday) with a diagnosis of ADHD.

2. Aim

To clarify the responsibilities and roles of specialists and GPs in the drug treatment of children and adolescents with ADHD.

3. Introduction

NICE Clinical Guideline ADHD: Diagnosis and management of ADHD in children, young people and adults (published September 2008, reviewed March 2018) indicates that the ongoing prescribing of medication may take place in primary care.

The NICE guidance states:

- For a diagnosis of ADHD, symptoms of hyperactivity/impulsivity and/or inattention should:
  - meet the diagnostic criteria in DSM-5 or ICD-10 (hyperkinetic disorder)[3]and
  - be associated with at least moderate psychological, social and/or educational or occupational impairment based on interview and/or direct observation in multiple settings, and
  - be pervasive, occurring in two or more important settings including social, familial, educational and/or occupational settings.
- As part of the diagnostic process, include an assessment of the person's needs, coexisting conditions, social, familial and educational or occupational circumstances and physical health. For children and young people, there should also be an assessment of their parents' or carers' mental health.
- Healthcare professionals should offer parents or carers of pre-school children with ADHD a referral to a parent-training/education programme as the first-line treatment if the parents or carers have not already attended such a programme or if the programme they attended has had a limited effect.
- Teachers who have received training about ADHD and its management should provide advice on behavioural support in the classroom.
- If the child or young person with ADHD has moderate levels of impairment, the parents or carers should be offered referral to a group parent-training/education programme, either on its own or together with a group treatment programme (cognitive behavioural therapy [CBT] and/or social skills training) for the child or young person.
  - In school-age children and young people with severe ADHD, drug treatment should be offered as the first-line treatment. In that instance, parents should also be offered a group-based parent-training/education programme.
- Drug treatment for children and young people with ADHD should always form part of a comprehensive treatment plan that includes psychological, behavioural and educational advice and interventions.

Medication

- Where drug treatment is considered appropriate, methylphenidate, lisdexamfetamine, dexamfetamine, atomoxetine and guanfacine are recommended, within their licensed indications, as options for the management of ADHD in children and adolescents in accordance with NICE Guideline NG 87.

- The decision regarding which product to use should be based on the following:
  - the presence of relevant comorbid conditions (for example, severe tic disorders, severe or unstable epilepsy, cardiac comorbidity)
  - the different adverse effects of the drugs
  - specific issues regarding compliance identified for the individual child or adolescent, for example problems created by the need to administer a mid-day treatment dose at school
  - the potential for drug diversion (where the medication is forwarded on to others for nonprescription uses) and/or misuse
  - the preferences of the child/adolescent and/or his or her parent or guardian.

- When prescribing methylphenidate for the treatment of children or young people, modified-release preparations should be considered for the following reasons:
  - convenience
  - improving adherence
  - reducing stigma (because the child or young person does not need to take medication at school)
  - reducing problems schools have in storing and administering controlled drugs
  - their pharmacokinetic profiles.

  Alternatively, immediate-release preparations may be considered if more flexible dosing regimens are required, or during initial titration to determine correct dosing levels.

- If there is a choice of more than one appropriate drug, the product with the lowest cost (considering the cost per dose and number of daily doses) should be prescribed.

- Following titration and dose stabilisation, prescribing and monitoring should be carried out under locally agreed shared care arrangements with primary care.

4. Abbreviations

- SCG: Shared Care Guideline
- CPFT: Cambridgeshire and Peterborough NHS Foundation Trust

5. Specific Medicines Information – Dose, Adverse Effects and Interactions

The following tables provide a summary of the most common adverse effects and their management, as well as clinically relevant drug interactions, of ADHD medications. Further details on the management of adverse effects of ADHD drugs are available from the European ADHD Guidelines Group (Cortese et al., J Child Psychology and Psychiatry, 2013).

For contraindications or further information please see the current BNF or summary of product characteristics for the individual drug.

Stimulant drug treatment

Methylphenidate Controlled Drug (Schedule 2)

Drug and dose information	Adverse effects	Clinically relevant drug interactions
Short acting • < 6 years - unlicensed • > 6 years – up to 60 mg daily in divided doses **Long acting** **Concerta XL /Matoride XL /** • < 6 years -unlicensed • > 6 years up to 54 mg once daily (higher doses may be used if recommended by specialist) **Equasym XL** • < 6 years -unlicensed • >6 years up to 60 mg once daily **Medikinet XL** < 6 years - unlicensed	• Nasopharyngitis • Sleep difficulties, insomnia • Agitation, anxiety • GI upset • Headache • Hypertension, arrythmia, tachycardia, palpitations • Cough • Reduced appetite, anorexia • Reduced rate of weight and height gain • Reduced rate of growth during prolonged use • Tics • Rarely blood disorder including leucopenia and thrombocytopenia	• MAOIs - risk of hypertensive crisis • Moclobemide - risk of hypertensive crisis • Clonidine - serious adverse events reported (causality not established)

Drug and dose information	Adverse effects	Clinically relevant drug interactions
> 6 years up to 60 mg once daily		

Lisdexamfetamine Controlled Drug (Schedule 2)

Drug and dose information	Adverse effects	Clinically relevant drug interactions
• > 6 years - 30mg once daily in the morning, increasing by 20mg daily • Increments at weekly intervals to a maximum of 70mg • Take with or without food. • Swallow whole or opened and dispersed in	• Reduced appetite a glass of water (take immediately) • Tics Upper abdominal pain • weight gain • Tachycardia • Headache • Sleep difficulties	MAOIs - risk of hypertensive crisis Chlorpromazine, haloperidol - effects of lisdexamfetamine possibly reduced

Dexamfetamine Controlled Drug (Schedule 2)

Drug and dose information	Adverse effects	Clinically relevant drug interactions
> 6 years - Initially 2.5 mg 2–3 times a day, increased in steps of 5 mg once weekly if required;, usual maximum 1 mg/kg daily, up to 20 mg daily (40 mg daily has been required in some children); maintenance dose to be given in 2–4 divided doses.	Sleep difficulties Reduced appetite GI symptoms Tachycardia Palpitations Arrhythmia	• MAOI's - risk of hypertensive crisis • Moclobemide - risk of hypertensive crisis

Non-stimulant drug treatment

Atomoxetine

Drug and dose information	Adverse effects	Clinically relevant drug interactions
• <6 years - unlicensed • >6 years **>70 kg,** 40 mg daily for 7 days increase according to response. Usual maintenance dose 80mg daily: max 100mg daily. **<70 kg,** 500 micrograms/kg daily for 7 days then increased according to response to Usual maintenance dose 1.2mg/kg daily: max 100mg daily	• GI Symptoms • Reduced appetite • Dry mouth • Palpitation, tachycardia • Increased blood pressure, increase in heart rate Dizziness, headache • Urinary retention, Sexual dysfunction, menstrual disturbance • Mydriasis, conjunctivitis • Dermatitis, sweating, weight • changes • Less commonly suicidal • ideation • Very rarely hepatic disorders.	• MAOIs - risk of hypertensive crisis. Atomoxetine should not be used within a minimum of 2 weeks after discontinuing therapy with MAOI. Treatment with MAOI should not be initiated within 2 weeks after discontinuing atomoxetine. • Salbutamol • Pressor agents or drugs that increase blood pressure. Increased risk of ventricular arrhythmias with • Antidepressants, Tricyclics • Diuretics, antihypertensive • Mefloquine • Methadone • Moxifloxacin

Guanfacine

Drug and dose information	Adverse effects	Clinically relevant drug interactions
Dosing in accordance with Summary of Product Characteristics: For all patients, the recommended starting dose is 1 mg of guanfacine, taken orally once a day.	• Decreased appetite, • Depression, • Anxiety,	• **CYP3A4 inducers** (e.g. bosentan, carbamazepine, efavirenz, etravirine, modafinil,nevirapine, oxcarbazepine, phenobarbital, phenytoin, primidone, rifabutin,

Drug and dose information	Adverse effects	Clinically relevant drug interactions
The dose may be adjusted in increments of not more than 1 mg per week. Dose should be individualized according to the patient's response and tolerability. Depending on the patient's response and tolerability for guanfacine hydrochloride (Intuniv®), the recommended maintenance dose range is 0.05-0.12 mg/kg/day. Dose adjustments (increase or decrease) to a maximum tolerated dose within the recommended optimal weight-adjusted dose range based upon clinical judgement of response and tolerability may occur at any weekly interval after the initial dose. Please see tables below for dosing in children (table 1) and young people (table 2). Patients/caregivers should be instructed not to discontinue guanfacine without consulting their doctor. When stopping guanfacine hydrochloride (Intuniv®), the dose must be decreased by 1 mg every 3 to 7 days, and blood pressure and pulse should be monitored in order to minimize potential withdrawal effects, increases in blood pressure and heart rate.	• Affect lability, insomnia, nightmare, Somnolence, headache, • sedation, • Lethargy, dizziness, bradycardia, hypotension, orthostatic hypotension, abdominal pain, • Vomiting, diarrhoea, nausea, • constipation, • Abdominal discomfort, • Dry mouth, • Rash, • Enuresis, • Fatigue, • Irritability, • Increase in weight.	rifampicin, St John's Wort.) - plasma concentration of guanfacine reduced. • **CYP3A4/5 inhibitors** (ketoconazole, boceprevir, clarithromycin, erythromycin, indinavir, itraconazole, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin) - Plasma concentration of guanfacine increased • **Antihypertensive medicines** – risk of hypotension / syncope • **Valproic Acid** - can result in increased concentrations of valproic acid with potential additive central nervous system (CNS) effects

Guanfacine titration tables:

Table 1: Dose Titration Schedule for Children Aged 6-12 years

Weight Group	Week 1	Week 2	Week 3	Week 4
25 kg and up Max Dose= 4 mg	1 mg	2 mg	3 mg	4 mg

Table 2 : Dose Titration Schedule for Adolescents (Aged 13-17 Years)

Weight Group	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7
34-41.4 kg Max Dose= 4 mg	1 mg	2 mg	3 mg	4 mg			
41.5-49.4 kg Max Dose= 5 mg	1 mg	2 mg	3 mg	4 mg	5 mg		
49.5-58.4 kg Max Dose= 6 mg	1 mg	2 mg	3 mg	4 mg	5 mg	6 mg	
58.5 kg and above Max Dose= 7 mg	1 mg	2 mg	3 mg	4 mg	5 mg	6 mg	7 mg

Further information about cautions and contraindications can be found in the Summary of Product Characteristics.

6. Monitoring Standards & Actions to take in the event of abnormal test results/symptoms

Monitoring

Methylphenidate, Dexamfetamine and Lisdexamfetamine

Parameter	Frequency of monitoring	Action	By Whom
Growth (weight and height) and Appetite	**Height:** 6 monthly in children and young people **Weight:** every 3 months in children 10 years and under. At 3 and 6 months after starting treatment in children over 10 years and young people, and every 6 months thereafter, or more often if concerns arise.	Many children lose a small amount of weight (about a kg) at the beginning of treatment. Weight and height should be plotted on published Growth Charts - see Appendix 1. If weight loss continues or if child's weight trajectory crosses more than one centile line or if this translates into the height trajectory being similarly affected: • Give information leaflet to help parents promote good diet - see Appendix 5 • reduce dose or encourage breaks from treatment at weekends/in school holidays Withdraw treatment.	Specialist at annual review GP at six months in between specialist reviews and three monthly if 10 years or under. –use proforma in appendix 2 and Appendix 3 to communicate
Cardiac function: heart rate, pulse and blood pressure	6 monthly, before and after each dose adjustment (Sustained resting tachycardia (>120bpm), arrhythmia or systolic blood pressure greater than the 95th percentile (or a clinically significant increase) should prompt referral to the secondary care provider) An ECG is only required at baseline if there is a clinical indication.	Monitor whilst taking medication to ensure within published range e.g. for age of child – see Appendix 1. If raised, repeat the measurement. The dose may need to be reduced, or arrangements may need to be made for 24-hour blood pressure readings. The ADHD clinic will be able to advise in liaison with the paediatricians.	Specialist at annual review GP at six months in between specialist reviews –use proforma in appendix 2 and Appendix 3 to communicate

Parameter	Frequency of monitoring	Action	By Whom
Onset or exacerbation of motor and verbal tics	6 monthly, before and after each dose adjustment.	Assess if the tics are related to the stimulant and the impairment associated with the tics outweighs the benefits of ADHD treatment If tics are stimulant related, reduce the stimulant dose, or consider changing to guanfacine (in children aged 6 years and over and young people only), atomoxetine, clonidine, or stopping medication.	Specialist at annual review GP at six months in between specialist reviews –use proforma in appendix 2 and Appendix 3 to communicate
New or worsening behaviour/ psychiatric symptoms	6 monthly, before and after each dose adjustment.	Monitor the behavioural response to medication, and if behaviour worsens adjust medication and review the diagnosis.	Specialist at annual review GP at six months in between specialist reviews –use proforma in appendix 2 and Appendix 3 to communicate
Sleep Pattern	Ongoing basis at appointments.	Monitor changes in sleep pattern (for example, with a sleep diary) and adjust medication accordingly.	Specialist/GP
Seizures	Ongoing basis at appointments.	If a person with ADHD develops new seizures or a worsening of existing seizures, review their ADHD medication and stop any medication that might be contributing to the seizures. After investigation, cautiously reintroduce ADHD medication if it is unlikely to be the cause of the seizures.	Specialist/GP
Full Blood count		Have a low threshold for carrying out an FBC e.g. if recurrent infections or purpuric rash occur. There is no need for routine testing.	GP

Atomoxetine

Parameter	Frequency of monitoring	Action	By Whom
Appearance of suicidal behaviour, self-harm or hostility.	Ongoing basis at appointments.	Patients/parents should be advised of this risk and made aware of possible signs/symptoms to report back to the specialist immediately if noticed.	Specialist and GP Telephone the on-call practitioner/on-call CAMHS psychiatrist to communicate in emergency
Cardiac function: heart rate, pulse and blood pressure	6 monthly before and after each dose adjustment (Sustained resting tachycardia (>120bpm), arrhythmia or systolic blood pressure greater than the 95th percentile (or a clinically significant increase) should prompt referral to the secondary care provider) An ECG is only required at baseline if there is a clinical indication.	Monitor whilst taking medication to ensure within published range e.g. for age of child – see Appendix 1.	Specialist at annual review GP at six months in between specialist reviews –use proforma in appendix 2 and Appendix 3 to communicate
Growth (weight and height) and Appetite	**Height**: 6 monthly in children and young people **Weight**: Every 3 months in children 10 years and under. At 3 and 6 months after starting treatment in children over 10 years and young people, and every 6 months thereafter, or more often if concerns arise.	Weight and height should be plotted on published Growth Charts - see Appendix 1.	Specialist at annual review GP at six months in between specialist reviews – use proforma in appendix 2 and Appendix 3 to communicate
Onset or exacerbation of motor and verbal	6 monthly, before and after each dose adjustment.	Assess if the tics are related to the drug and the impairment associated with the tics	Specialist at annual review GP at six months in between specialist reviews

Parameter	Frequency of monitoring	Action	By Whom
tics		outweighs the benefits of ADHD treatment.	–use proforma in appendix 2 and Appendix 3 to communicate
Sleep Pattern	Ongoing basis at appointments.	Monitor changes in sleep pattern (for example, with a sleep diary) and adjust medication accordingly.	Specialist/GP
Sexual dysfunction	Ongoing basis at appointments.	Monitor young people and adults with ADHD for sexual dysfunction (that is, erectile and ejaculatory dysfunction.	Specialist/GP
Seizures	Ongoing basis at appointments.	If a person with ADHD develops new seizures or a worsening of existing seizures, review their ADHD medication and stop any medication that might be contributing to the seizures. After investigation, cautiously reintroduce ADHD medication if it is unlikely to be the cause of the seizures.	Specialist/GP
Blood tests for liver function	If abdominal pain, unexplained nausea, jaundice, darkened urine or malaise.	If an adverse effect is suspected the secondary care provider should be contacted for advice and an urgent assessment GP to copy in specialist to any blood tests undertaken	Specialist/GP

Guanfacine

Parameter	Frequency of monitoring	Action	By Whom
Cardiac function: heart rate, pulse and blood pressure	Every 3 months for the first year then every 6 months.	Signs of bradycardia and hypotension should prompt referral to the specialist. Ensure heart rate / pulse and blood pressure are monitored at each dose adjustment.	Specialist at annual review GP at 3 months in the first year (if already prescribing) and then every 6 months in between specialist reviews –use proforma in appendix 2 and Appendix 3 to communicate
Growth (weight and height) and Appetite	BMI every 3 months for the first year then every 6 months.	Weight and height should be plotted on published Growth Charts - see Appendix 1.	Specialist at annual review GP at 3 months in the first year (if already prescribing) and then every 6 months in between specialist reviews –use proforma in appendix 2 and Appendix 3 to communicate
Somnolence / Sedation	Every 3 months for the first year then every 6 months.	If problematic specialist to adjust dose or GP to contact specialist to discuss.	GP in between specialist reviews as indicated
New or worsening behaviour/ psychiatric symptoms	6 monthly, before and after each dose adjustment.	Monitor the behavioural response to medication, and if behaviour worsens adjust medication and review the diagnosis.	Specialist at annual review GP at six months in between specialist reviews –use proforma in appendix 2 and Appendix 3 to communicate
Sleep Pattern	Ongoing basis at appointments.	Monitor changes in sleep pattern (for example, with a sleep diary) and adjust medication accordingly.	Specialist/GP
Blood tests for liver function	If abdominal pain, unexplained nausea, jaundice, darkened urine or malaise.	If an adverse effect is suspected the secondary care provider should be contacted for advice and an urgent assessment GP to copy in specialist to any blood tests undertaken.	Specialist/GP

7. Shared Care Responsibilities

a. Specialist responsilities:

- Undertake assessment and diagnose, identify patients who will benefit from treatment with medication.
- Undertake pre-treatment monitoring including baseline cardiovascular risk assessment and advise the GP of the outcome of this.
- Assess atomoxetine patients on an ongoing basis for appearance of suicidal behaviour, self-harm or hostility. Have a low threshold for booking patients in for review if concerns are expressed.
- Check drug-drug and drug-disease interactions e.g. establish any history of cardiac or epileptic conditions and any concurrent medicines
- Initially prescribe and stabilise the patient on the chosen medication (usually about 3 months).
- Monitor height, weight, blood pressure and pulse every 6 months (every 3 months for guanfacine), then at annual reviews.
- When appropriate, invite GP to share care.
- Advise GP about the treatment and about what has been explained to the parent/patient.
- Continue to prescribe for the patient after initiation of treatment until the GP agrees to accept prescribing responsibility and provide prescriptions for the patient.
- Communicate promptly with the GP about any changes in treatment and respond promptly to any concerns raised by the GP.
- Monitor the efficacy and adverse effects of the treatment at least annually, considering whether continuation is necessary.
- Advise the GP about any individual variations from this protocol for an individual patient.
- Ensure the patient/parent/carer are fully informed of the potential benefits and side effects of treatment and ensure the person with parental responsibility (and where appropriate, the young person) consents to the treatment. Share with the GP any information about consent that s/he needs to know.
- Ensure clear arrangements are in place for back up, advice and support e.g. out of hours and/or when the consultant initiating therapy is not available.
- Educate the family about the drug therapy to maximise compliance and when to seek medical advice.
- With consent, liaise with the school, providing education about ADHD, drug therapy and storage.
- Evaluate any adverse effects reported by the GP (Any adverse effects which are suspected to relate to the drug should be reported via the Yellow Card System).
- Refer for additional behavioural therapy (social skills, anger management or parents' group/parenting skills) when appropriate.
- Arrange transfer to adult services if medication is to continue over the age of 17.

b. General Practitioner:

- Ensure that shared care arrangements are in place before taking over prescribing/monitoring and:
- That the patient/carer is clear what is being monitored and by whom.
- That the patient/carer knows what significant adverse effects/events to report urgently and to whom they should report (specialist or GP).
- Confirm that proposed therapy is not contra-indicated because of concurrent therapy for other conditions the patient may be suffering from e.g. check drug-drug and drug-disease interactions.
- Prescribe methylphenidate/dexamfetamine/lisdexamfetamine/atomoxetine or guanfacine at the dose recommended by the specialist once the patient is stabilised on treatment and side effects have been excluded as far as possible by the specialist team (usually after 3 months).
- Be aware of the potential of Atomoxetine to (rarely) precipitate suicidal behaviour, self-harm or hostility particularly where there is a history of depression or suicidal behaviour. Ask specialist for an early review if needed as a matter of urgency.
- Discuss potential benefits and side effects of treatment with the patient/carer to address any outstanding queries.
- Monitor height, weight, blood pressure and pulse annually six months after the annual specialist review or more frequently if there are specific concerns and at the request of the specialist. Check these against standard charts (see Appendix 1) or fax/email the observations to the specialist clinic who will be happy to provide guidance. If in doubt about effectiveness or side-effects, share this information with the specialist clinic. Seek advice from the specialist team if the patient does not attend for monitoring appointments.
- Arrange appropriate investigations (FBC) if patients present with unexplained bruising; consider withdrawal of medication; seek paediatric/haematology advice and contact the specialist team.
- Arrange appropriate investigation if the patient shows signs of liver problems and discontinue the medication if the person has jaundice or has laboratory evidence of hepatic injury. Seek paediatric/gastroenterology advice and contact the specialist team.
- Check for possible drug interactions when newly prescribing or stopping concurrent medication.
- Report any suspected adverse drug reactions to the specialist who initiated therapy under the shared care agreement. Report adverse events via the yellow card scheme.
- Monitor compliance through rates of prescription.

c. Patient/carer:

- Discuss potential benefits and side effects of treatment with the specialist and GP, raise any outstanding queries.
- Report any adverse effects to their specialist or GP whilst child/young person is taking drug(s).
- Report to the specialist or GP if they do not have a clear understanding of their treatment.

- Report to the specialist or GP if their child is not taking the medication willingly so that consent issues can be assessed.
- Attend all appointments suggested in the time frame advised so that the therapy can be properly monitored. This includes booking appointments in primary care as suggested by the specialist. Be aware that if monitoring is not possible because appointments are not made and attended, it may not be possible for the medication to continue.
- For children who need to take medication during the school day, ensure that school have a supply of tablets.
- Store the tablets safely out of the reach of children and young people keeping in mind that all medication is dangerous if taken in over-dose.

8. Monitoring compliance with and the effectiveness of this document

Compliance with this document will be undertaken using a risk-based approach if necessary.

9. Equality and Diversity Statement

This document complies with the CPFT Equality and Diversity statement.

10. Disclaimer

It is your responsibility to check that this printed out copy is the most recent issue of this document.

11. Document Management

Ratification Process	**Details**
Authored by:	Cambridgeshire and Peterborough NHS Foundation Trust
Ratified by:	Cambridgeshire and Peterborough Joint Prescribing Group
Date ratified:	December 2019
Review date:	December 2021
Version number:	6

The information contained in this guideline is issued on the understanding that it is accurate based on the resources at the time of issue. For further information please refer to the most recent Summary of Product Characteristics.

Appendix 1 – Resources

- Standard growth charts are available from http://www.rcpch.ac.uk/child-health/researchprojects/uk-who-growth-charts/uk-growth-chart-resources-2-18-years/uk-2-18-years

- Blood pressure can be checked against population norms such as the NIH charts which allow readings to be checked against gender, age and height centile http://www.nhlbi.nih.gov/files/docs/guidelines/child_tbl.pdf

Blood pressure, pulse, weight and height measurements may be faxed or emailed to the specialist clinic using the proforma in Appendix 2 or 3. SystmOne is used by the ADHD care pathway in City Care Centre. If your health centre/surgery also uses SystmOne, the measurements you have entered will appear in the patient profile. However, there is still a need for you to communicate to us that you have done so by fax or email.

Please indicate if you require a response from the specialist clinic. The contact details for sending these values to the clinics are:

Contact numbers for advice and support

	Telephone	Fax	Emails (secure for emails sent from an NHS.net email account)
Brookside Family Consultation Clinic, Cambridge	01223 465100		cpm-tr.camhsadminteam@nhs.net
Newtown Centre, Huntingdon and Doddington Hospital	01480 445281 (Huntingdon) 01354 644257 / 644258 (Doddington)	01480 445349	cpftneurodevelopmentalpathway@cpft.nhs.uk
City Care Centre / Winchester Place, Peterborough	01733847022 01733 777939		Cpm-tr.neurodevelopmentteam@nhs.net

Appendix 2

Brief health check for CAMHS ADHD patients in primary care

Patient Name:

Date of birth or NHS number:

The above patient was seen in primary care on:

Blood pressure:

Pulse rate:

Weight

Height

Motor/verbal tics

Behaviour/psychiatric symptoms

Seizures

Any other comments

Please tick if you would like the ADHD clinic to advise about continued treatment ☐

Name/designation:

Name of health centre/surgery:

Thank you. Please fax or email this record to the ADHD clinic (if you have urgent concerns, you should phone and speak to the duty practitioner or doctor)

Appendix 3

Notification of CAMHS ADHD health check in primary care (for patients being seen in City Care Centre only)

Name/designation:

Name of health centre/surgery:

Patient Name:

Date of birth or NHS number:

The above patient was seen on date and his/her SystmOne profile was updated with Blood Pressure, Pulse rate, Weight and Height.

Any other Comments:

Indicate if you would like the ADHD clinic to advise about continued treatment

☐

Thank you. Please fax or email this record to the ADHD clinic (if you have urgent concerns you should phone and speak to the duty practitioner or doctor)

Appendix 4

Advice to Primary Care from the ADHD Clinic

Patient Name:

Date of birth or NHS number:

Thank you for sending in the above patient's physical measurements.

Having seen this information and checked the patient's record, I can advise the following:

Advice:

Signature: Name of HPC:

Designation of HPC:

Name of ADHD clinic:

This advice to be sent to the GP and copied to parents/carers

Appendix 5

Eating for Health for children with ADHD