

Madigan Army Medical Center Referral Guidelines

Attention Deficit Hyperactivity Disorder

Diagnosis/Definition

Definition

- Children present with varying symptoms of impulsivity, hyperactivity, and/or inattention which are excessive for age, are evident early in childhood and persistent, are present in more than one setting, and which adversely affect academic, behavioral, emotional, and/or social functioning.
- ADHD remains a clinical diagnosis; there are no biological markers or psychological tests which are diagnostically specific.

Diagnosis

- Primary care clinicians should consider ADHD in a child presenting with any of the following concerns:
 - Can't sit still/hyperactive
 - Lack of attention/poor concentration/doesn't seem to listen/daydreams
 - Acts without thinking/impulsive
 - Behavior problems
 - Academic underachievement
- The diagnosis of ADHD requires evidence that a child meets DSM-IV criteria.
- At least 6 symptoms of Inattention and/or Hyperactivity-Impulsivity often present.
- Behaviors occur to a greater degree than other children the same age
- Behaviors present by age 7 years and persist on regular basis for more than 6 months
- Behaviors occur in more than one setting such as home, school, and social situations.
- Behaviors adversely affect functioning in school, social, or other areas
- Behaviors are not better accounted for by another disorder

Initial Diagnosis and Management

- Prior to referral to the ADHD Diagnostic Clinic (as a Developmental Pediatrics consultation), primary care providers (Peds and non-Peds care providers) should perform:
 - Standard history and physical examination
 - Hearing and vision screen, if not done within past year.
 - There is no need to obtain parent or teacher rating forms as the ADHD Diagnostic Clinic performs a 2 step evaluation and will provide families with all necessary forms after the first visit.

Ongoing Management and Objectives

- Collaborate with parents, child, and school staff to specify appropriate target symptoms and functional outcomes to guide management.
- Common examples:
 - Improve relationships with family members, teachers, and peers
 - Decrease disruptive behaviors

- Improve academic performance, particularly in volume of work, efficiency, completion, and accuracy
- Increase independence in self-care or homework
- Improve self-esteem
- Improve safety in community, such as crossing streets, riding bikes.
- Recommend stimulant medication* and/or behavior therapy, as appropriate, to improve target outcomes (*See Pharmacy's therapeutic guidelines for medication recommendations).
- Provide systematic follow-up and monitor target outcomes and adverse medication effects by obtaining specific information from parents, child and teacher. (parent/teacher monitoring forms can be downloaded from <http://www.aap.org/pubserv/adhdtoolkit/index.htm>)

Indications for Specialty Care Referral

- Evaluation by a pediatric specialist (child psychologist, child psychiatrist, or developmental-behavioral pediatrician) is suggested for:
 - Children younger than age 6 years
 - When the following diagnoses or problems are present or suspected:
 - Comorbid developmental, emotional or behavioral disorders (including oppositional-defiant or conduct disorder; mood or anxiety disorder; tic disorder; drug or alcohol abuse; pervasive developmental disorder; mental retardation)
 - Medical condition which complicates management (e.g., seizure disorder)
 - Severe aggression or self-injury
 - History of abuse or other severe psychosocial stressors
 - Children who continue to have problems despite treatment Children on multiple medications
- Evaluation by the MAMC ADHD Diagnostic team can performed on any school age child (age 5-12) where ADHD symptoms are present. Following two step evaluation and visit for treatment recommendations when necessary, patient will be returned to primary care provider for ongoing management. Evaluation can be initiated by placing a DEVELOPMENTAL PEDIATRIC CONSULTATION

Criteria for Return to Primary Care

- Completed specialty care evaluation with established diagnosis, evidence of co-morbid diagnoses, change in medication recommendations, etc with recommendations that can be accomplished at a primary care level.
- A level of involvement that can be managed by a primary care manager with ongoing monitoring by subspecialists.

Last Review for this Guideline: **May 2009**

Referral Guidelines require review every three years.

Maintained by the Madigan Army Medical Center - Quality Services Division
Clinical Practice and Referral Guidelines Administrator