Harley Mind Care
Psychiatrists Ltd

ADULT ADHD & AUTISM
GP REFERRAL FORM
NHS Right to Choose

BEFORE YOU BEGIN — Please answer the question below

Is your patient registered with a Kent and Medway GP?

☐ YES — Complete this form in full and submit to: kmicb.harleymindcare.adhdautism@nhs.net

☐ NO — Complete Sections 2–4 only and submit to: kmicb.harleymindcare.adhdautism@nhs.net — we will contact you once arrangements with your ICB are confirmed. eRS submission will be available shortly.

Harley Mind Care holds an NHS Right to Choose contract with NHS Kent and Medway ICB. We are actively expanding nationally and in discussion with ICBs across England. All fields marked * are mandatory.

1. Referral Type (Mandatory — tick as appropriate)

☐ Adult ADHD Assessment and Treatment (Video Consultation) ☐ Adult Autism (ASD) Assessment (Video Consultation)

☐ ADHD Medication Titration or Annual Review (Video Consultation — existing patients only) — For titration referrals include current prescriber name and diagnosis provider. A discharge letter is required if referred directly to titration without a new HMC assessment.

Does the patient have an existing ADHD diagnosis? ☐ Yes (please attach report) ☐ No

Does the patient have an existing ASD diagnosis? ☐ Yes (please attach report) ☐ No

All assessments are delivered via secure video consultation. If the patient is unable to access video consultation, please note this in Section 11 and we will discuss suitable alternatives. ADOS-2 (autism) requires a separate face-to-face appointment where clinically necessary — this will be arranged following initial triage. Adult patients (18+) only under the K&M contract. CYP referrals are not currently commissioned under NHS Kent and Medway ICB — for CYP enquiries please contact hello@harleymindcare.com.

2. Patient Details (Mandatory)

Title:	First name*:	Surname*:	Preferred name:
Date of birth*:	**NHS Number* (10 digits):**		
Ethnicity*:	**Language / preferred language:**		
Phone number*:	**Email address*:**		
Patient postal address*:			

3. Contact Information

Patient email is required to provide access to our patient portal and for appointment communications.

Does the patient or their carer have any communication, language, hearing, speech or vision needs?
(Accessible Information Standard — NHS legal requirement)

Interpreter / BSL / lip speaker required? ☐ Yes (please specify language/type below) ☐ No

4. GP / Referrer Details (Mandatory)

GP Practice name and full address*:

GP telephone number*:	**GP email address*:**
GP ODS code:	**ICB name and area*:**
ICB contact email (for all NHS correspondence):	**Date of request:**
Referrer name*:	**Role* (GP / ANP / ACP):**

Referrals must be made by a GP, Advanced Nurse Practitioner (ANP) or Advanced Clinical Practitioner (ACP).

Complete Sections 5–11 only if patient is registered with a Kent and Medway GP

5. Summary Care Record & Current Medications (K&M only)

Is a Summary Care Record (SCR) being sent with this referral? ☐ Yes ☐ No (please provide medications list below)

Current medications (including dose and frequency):

Known allergies and adverse reactions:

6. Suicidality Risk Screening (K&M only — Mandatory)

Please evaluate the patient's current level of risk. If any high-risk indicators are identified, initiate urgent escalation before making this referral — we are unable to deliver services to patients in active crisis. For PRIORITY referrals include "PRIORITY REFERRAL" in the subject line of your email.

☐ There are no reported suicidal ideations, significant distress, or history of self-harm.
→ **Patient may proceed with the standard referral pathway.**

☐ The patient has reported suicidal ideation within the past two weeks, with no current plan or intent.
→ **Priority assessment is recommended. Include "PRIORITY REFERRAL" in subject line.**

☐ The patient is presenting with active suicidal ideation, including a plan and/or access to means, or has a recent history of suicide attempt or self-harm.
→ **STOP. Immediate escalation to crisis services required BEFORE submitting this referral.**

7. Physical Health Risk Screening (K&M only)

☐ The patient has a life-limiting physical health condition.
→ **Priority assessment is recommended. Please provide details below.**

Physical health details (if applicable):

8. Reason for Referral (Mandatory — K&M only)

Include clinical rationale. For ADHD, describe symptoms in two or more settings (e.g. home and work). For autism, describe communication, social interaction and sensory concerns. Include relevant childhood history where possible.

Clinical rationale*:

9. Risks & Safeguarding (K&M only)

Tick all that apply. If any apply, provide further detail or attach corresponding correspondence.

☐ Suicide / self-harm ☐ Self-neglect ☐ Substance misuse ☐ Risk from others

☐ Risk to others ☐ CMHT involvement ☐ Section 117 aftercare ☐ Active safeguarding issues

☐ Recent police involvement ☐ Recent acute MH admission ☐ Active psychosis ☐ Mental capacity concerns

Further detail (attach letters if available):

10. Suitability and Exclusion Criteria (K&M only)

ADULT REFERRALS (18+)

Please confirm none of the following apply before submitting. Hard exclusions (marked ✗) cannot be accepted under NHS funding. Items marked with ⚠ require contact with HMC before referral.

✗ HARD EXCLUSION The patient has previously had a completed NHS assessment for ADHD or autism (with or without diagnosis). The NHS will not fund a second assessment.

✗ HARD EXCLUSION The patient is currently serving a prison sentence, is on probation, or is on temporary release.

✗ HARD EXCLUSION The patient is a serving member of the armed forces. MOD healthcare routes apply.

⚠ DISCUSS FIRST The patient is unable to communicate at a conversational level in English. Please contact us to discuss before referring.

☐ Check The patient is non-verbal or selectively mute.

☐ Check The patient has a significant intellectual disability (IQ below 70) or severe developmental delay.

☐ Check The patient has a significant visual or hearing impairment preventing online engagement.

☐ Check The patient is currently experiencing psychosis or has had a psychotic episode within the past six months.

☐ Check The patient has an active eating disorder or has been discharged from a specialist eating disorder service within the past six months.

☐ Check The patient's drug or alcohol use is significantly impacting daily life or they are currently in treatment for substance addiction.

☐ Check The patient has a traumatic/acquired brain injury, has undergone brain surgery, or has a neurological condition affecting cognitive function.

☐ Check The patient is undergoing a safeguarding investigation, has a child protection plan, or is involved in an ongoing police or criminal investigation. Assessments can only proceed once these matters are resolved.

☐ Check The patient is detained under the Mental Health Act 1983 or is subject to a Community Treatment Order.

☐ Check The patient does not have access to a laptop or desktop computer with a microphone and webcam. Mobile phones cannot be used.

☐ Check The patient does not have access to a private and reliable internet connection for the assessment.

☐ Check The patient is unwilling to conduct the assessment with their camera on for the full duration.

☐ I confirm the above criteria have been reviewed and the patient is appropriate for adult referral to Harley Mind Care Psychiatrists Ltd.

CYP REFERRALS (5–17) — NOT CURRENTLY COMMISSIONED UNDER K&M ICB

CYP services are not currently commissioned under the NHS Kent and Medway ICB contract. This section applies to out-of-area and future CYP referrals only. For K&M CYP enquiries please contact hello@harleymindcare.com. We are actively seeking the K&M CYP contract.

✗ HARD EXCLUSION The child or young person is under the age of 5.

✗ HARD EXCLUSION The child or young person has previously had a completed NHS assessment for ADHD or autism. The NHS will not fund a second assessment.

✗ HARD EXCLUSION The child or young person is currently serving a custodial sentence, is on probation, or is on temporary release.

⚠ DISCUSS FIRST The child or young person is unable to communicate at a conversational level in English. Please contact us before referring.

☐ Check The child or young person is non-verbal or selectively mute.

☐ Check The child or young person has a significant intellectual disability (IQ below 70) or severe developmental delay.

☐ Check The child or young person has a significant visual or hearing impairment preventing online engagement.

☐ Check The child or young person is currently experiencing psychosis or has had a psychotic episode within the past six months.

☐ Check The child or young person has an active eating disorder or has been discharged from a specialist eating disorder service within the past six months.

☐ Check The child or young person's drug or alcohol use is significantly impacting daily life.

☐ Check The child or young person has a traumatic/acquired brain injury or a neurological condition affecting cognitive function.

☐ Check The child or young person is undergoing a safeguarding investigation, has a child protection plan, or is involved in an ongoing police or criminal investigation. Assessments can only proceed once resolved.

☐ Check The child or young person is detained under the Mental Health Act 1983 or is subject to a Community Treatment Order.

☐ Check The family does not have access to a laptop or desktop computer with a microphone and webcam. Mobile phones cannot be used.

☐ Check The family does not have access to a private and reliable internet connection for the assessment.

☐ Check The child or young person is unwilling to conduct the assessment with their camera on for the full duration.

☐ I confirm the above criteria have been reviewed and the child/young person is appropriate for CYP referral to Harley Mind Care Psychiatrists Ltd.

11. Additional Information / Needs

Please specify any additional requirements, e.g. translation, accessibility or reasonable adjustments not already captured above.

Additional information:

12. Third Party Consent (if applicable)

If the patient wishes to involve a third party (e.g. carer or family member) in their care, please provide their details below.

Name:	Relationship to patient:	Contact number:	Email:

13. Shared Care Agreement (Mandatory for ADHD referrals — K&M only)

Under the K&M Shared Care Agreement, Harley Mind Care will provide initial assessment, diagnosis, prescribing and titration. The GP will take over ongoing prescribing once the patient is stable, supported by an annual HMC review. The patient must attend the annual review for the GP to continue prescribing. K&M ADHD Shared Care Guidance: kentandmedwayformulary.nhs.uk

This practice confirms it is willing to accept Shared Care for this patient if diagnosed and successfully completing titration. ☐ Yes ☐ No

If Shared Care is declined, HMC will retain prescribing responsibility. Annual review will be conducted by HMC at no additional cost to the ICB.

14. Referrer Declaration (Mandatory — must be GP, ANP or ACP)

By signing below I confirm that: (1) I have obtained the patient's consent to this referral; (2) the patient does not meet the exclusion criteria set out in Section 10; (3) the clinical information provided is accurate to the best of my knowledge; (4) I agree to receive shared care correspondence from Harley Mind Care Psychiatrists Ltd.

Referrer name (print)*:	GMC / NMC / HCPC number:	Signature:	Date*:

GP practice stamp (if available):

Kent & Medway — complete form in full:	Out-of-area — Sections 2–4 only:
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