Dear Colleague:

Attention-deficit/hyperactivity disorder (ADHD) is challenging for children, families, schools, and clinicians. The American Academy of Pediatrics (AAP) has developed this toolkit to assist clinicians in providing quality care for children with ADHD. An unrestricted educational grant to support the development, production, and dissemination of this toolkit was provided by McNeil Consumer and Specialty Pharmaceuticals.

Rooted in the evidence-based AAP guidelines for the diagnosis and treatment of children with ADHD, this toolkit provides excellent resources for clinicians. These tools can provide the basis for a coordinated, integrated, and multidisciplinary system of care. We hope to encourage collaboration among primary care professionals, school personnel, parents, and children.

Using initial development funds from the Centers for Education and Research on Therapeutics (CERTs) at the University of North Carolina, funded by the Agency for Healthcare Research and Quality (federal grant 5 U18 HS10397—"Rational Therapeutics for the Pediatric Population"), the National Initiative for Children's Healthcare Quality (NICHQ) worked with experts to identify and catalog resources to assist clinicians who care for children with ADHD. The 75 tools initially collected included those in the public domain and those contributed by clinical and educational specialists. NICHQ worked with the AAP ADHD Guidelines Implementation Project Advisory Committee to cull the library of tools to a manageable number that could be tested and adapted more easily. The 30 primary care practices participating in NICHQ's Learning Collaborative, Improving Care for Children with ADHD, used and modified the tools; 4 of these practices, from the AAP Pediatric Research in Office Settings (PROS) network, worked closely with NICHQ staff to give specific feedback and suggestions for improvement (Panorama Pediatrics Group, Rochester, NY; St Johnsbury Pediatrics, St Johnsbury, VT; Children's Hospital of Michigan, Detroit; and Nemours and Orlando Regional Healthcare Pediatric Outpatient Department, Orlando, FL). Finally, Harlan Gephart, MD, and Laurel Leslie, MD, reviewed the revised tools, ensuring that they are accurate and user-friendly.

Additional forms can be downloaded from the AAP Members Only Channel on the AAP Web site (www.aap.org/moc). The AAP online program, Education for Quality Improvement for Pediatric Practice (eQIPP), will have a module on ADHD available in spring 2003 that will provide downloadable tools and interactive case scenarios. The AAP is committed to exploring opportunities to update the toolkit to ensure users have the most current and timely resources available.

We hope this toolkit will serve as a valuable resource in your practice.

Joe M. Sanders, Jr, MD
Executive Director
American Academy of Pediatrics
INTRODUCTION

Attention-deficit/hyperactivity disorder (ADHD) is one of the most common chronic childhood disorders. Current estimates indicate that 4% to 12% of all school-aged children may be affected. ADHD is a neurobehavioral disorder that usually appears in children before the age of 7.

Children with ADHD may have difficulty controlling their behavior in school and social settings and often fail to achieve their full academic potential. Clinically, the child may present with varying symptoms of hyperactivity, impulsivity, and/or inattention. The child may be easily distracted, be unable to pay attention and follow directions, be overactive, and/or have poor self-control.

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), characterizes the following 3 subtypes of ADHD:

- **Inattentive only (ADHD-IA)** (formerly known as attention-deficit disorder (ADD))—Children with this form of ADHD are not overly active. Because they do not disrupt the classroom or other activities, their symptoms may not be noticed. Among girls with ADHD, this form is most common. Approximately 30% to 40% of children with ADHD have this subtype.

- **Hyperactive/Impulsive (ADHD-H/I)**—Children with this type of ADHD show hyperactive and impulsive behavior but can pay attention. This subtype accounts for a small percentage, approximately 10%, of children with ADHD.

- **Combined Inattentive/Hyperactive/Impulsive**—Children with this type of ADHD show all 3 symptoms. This is the most common type of ADHD. The majority of children with ADHD have this subtype, approximately 50% to 60%.

The diagnosis of ADHD relies on the documentation of symptoms that are associated with functional impairment from multiple environments. Because of this, school personnel, families, and primary care clinicians need to work collaboratively to document specific symptoms and their effect on a child’s functioning. School personnel and families also need to be aware that there currently are no biological markers or computerized tests that allow for diagnostic specificity.

Once a diagnosis of ADHD has been made with confidence, the primary care clinician can approach the issue of treatment of the child with ADHD. This involves developing a management plan that incorporates the appropriate medication and/or behavior therapy to meet target outcomes. The care of most children with ADHD can be managed in a primary care setting.

The role of the primary care clinician is to

- Synthesize and interpret information about a child’s behavior.
- Identify other medical or psychosocial problems that might be causing and/or exacerbating the child’s symptoms.
- Refer for further evaluation where needed.
- Arrange other treatment (eg, educational, psychological) as needed.
- Provide appropriate medical treatment.
- Monitor progress.
- Support parents in their role as advocates for the child.
Caring for Children With ADHD: A Resource Toolkit for Clinicians

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DIAGNOSIS

Diagnosis and Evaluation of the Child With Attention-Deficit/Hyperactivity Disorder

An effective treatment begins with an accurate, well-established diagnosis.

This AAP clinical practice guideline contains the following recommendations for diagnosis of ADHD:

1. In a child 6 to 12 years old who presents with inattention, hyperactivity, impulsivity, academic underachievement, or behavior problems, primary care clinicians should initiate an evaluation for ADHD.

2. The diagnosis of ADHD requires that a child meet Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), criteria.

3. The assessment of ADHD requires evidence directly obtained from parents or caregivers regarding the core symptoms of ADHD in various settings, the age of onset, duration of symptoms, and degree of functional impairment.

4. The assessment of ADHD requires evidence directly obtained from the classroom teacher (or other school professional) regarding the core symptoms of ADHD, duration of symptoms, degree of functional impairment, and coexisting conditions.

5. Evaluation of the child with ADHD should include assessment for associated (coexisting) conditions.

6. Other diagnostic tests are not routinely indicated to establish the diagnosis of ADHD but may be used for the assessment of other coexisting conditions (eg, learning disabilities, mental retardation).

This clinical practice guideline is not intended as a sole source in the evaluation of children with ADHD. Rather, it is designed to assist primary care clinicians by providing a framework for diagnostic decision making. It is not intended to replace clinical judgment or to establish a protocol for all children with the condition.

Tools

NICHQ ADHD Primary Care Initial Evaluation Form

Intended for use by the clinician, this tool helps organize the various pieces of information needed to make a diagnosis of ADHD: patient history; pertinent physical examination including vision, hearing, and neurologic screening; and data from the assessment scales (described below). This form also can serve to ensure the child has received a treatment plan, appropriate referrals, and a follow-up appointment. This sample is provided as a template; a clinician can adapt this tool to fit his or her own practice and approach.

The NICHQ Vanderbilt Parent and Teacher Assessment Scales

NICHQ Vanderbilt Assessment Scale—PARENT Informant
NICHQ Vanderbilt Assessment Scale—TEACHER Informant
NICHQ Vanderbilt Assessment Follow-up—PARENT Informant
NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant

Scoring Instructions for the NICHQ Vanderbilt Assessment Scales

SAMPLE NICHQ Vanderbilt Assessment Scale—PARENT Informant

A child must meet DSM-IV criteria for a diagnosis of ADHD to be appropriate. To confirm a diagnosis of ADHD, these behaviors must

• Occur in more than one setting, such as home, school, and social situations
• Occur to a greater degree than in other children the same age
• Begin onset before the child reaches 7 years of age and continue on a regular basis for more than 6 months
• Significantly impair the child’s academic and social functioning
• Not be better accounted for by another disorder

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DIAGNOSIS, CONTINUED

Many school-aged children have some of these symptoms, either transiently or in a mild form, and it is important to establish the high frequency of symptoms to make the diagnosis of ADHD. The NICHQ Vanderbilt Parent and Teacher Assessment Scales are one way to do this. The NICHQ Vanderbilt Assessment Scales also screen for the following coexisting conditions: oppositional-defiant disorder, conduct disorder, and anxiety and depression. If a screen is positive, a more detailed evaluation is warranted. It also should be noted that the scales will not pick up learning disabilities, suicidal behaviors, bipolar disorder, alcohol and drug use, or tics—all of which may be present in a child with ADHD.

The NICHQ Vanderbilt Assessment Follow-up tools help assess the treatment’s effectiveness. There are forms for use by the parent and teacher. Intended for use by the clinician and staff, the scoring instructions provide a set of directions for scoring the NICHQ Vanderbilt Assessment and Follow-up Scales.

Cover Letter to Teachers

This serves as a means of communication and an introductory letter that may accompany the assessment scales that you request from the school. It is suggested that a “release of information” form, signed by the parent, accompany the letter. This sample is provided as a template; a clinician can adapt this tool to fit his or her own practice and approach.

The NICHQ Vanderbilt Parent Assessment Scale

How to score the parent checklist

The NICHQ Vanderbilt scale is divided into 2 sections: Symptoms and Performance. When handing the assessment scale to the parent, point out how to fill out the form correctly.

- The Symptoms section identifies the frequency of occurrence. Direct the parent to circle only 1 of the 4 numbers on the scale.
- The Performance section indicates the level of impairment. Direct the parent to circle only 1 of the 5 numbers on the scale.

Once the form is completed, the ADHD subtype can be determined.

a. For questions 1–9, add up the number of questions where the parent circled a 2 or 3.
b. For questions 10–18, add up the number of questions where the parent circled a 2 or 3.
c. For questions 48–55, add up the number of questions where the parent circled a 4 or 5.

- For Predominantly Inattentive subtype, at least 6 of questions 1–9 must score a 2 or 3. In addition, at least 1 of questions 48–55 must score a 4 or 5.
- For Predominantly Hyperactive/Impulsive subtype, at least 6 of questions 10–18 must score a 2 or 3. In addition, at least 1 of questions 48–55 must score a 4 or 5.
- For Combined Inattention/Hyperactivity subtype, at least 6 of questions 1–9 and 6 of questions 10–18 must score a 2 or 3. Additionally, at least 1 of questions 48–55 must score a 4 or 5.

What to tell the parent while you are scoring

You can walk a parent through what you are doing. This is helpful in educating them about their child’s condition.

Note: Alternately, staff can score the rating scale. The parent can turn the scale in to the front desk, and a nurse or administrative assistant can score it and attach it to the patient’s file. Some clinicians also use questionnaires to collect the history as well as DSM-IV criteria and score this packet prior to seeing the child and family. This may allow for a more efficient use of time in the office.
DIAGNOSIS, CONTINUED

The NICHQ Vanderbilt Teacher Assessment Scale

Teachers often are the first to notice behavior signs of possible ADHD. Children 6 to 12 years of age spend many of their waking hours at school, and the teacher is a powerful source of information about the child's behaviors, interactions, and academic performance. To make an accurate diagnosis, information about the child will be needed directly from the child's classroom teacher or another school professional. The child's academic and classroom behavior is necessary to corroborate the diagnosis and identify potential learning disabilities.

The guideline specifies that this information can be obtained using narratives from the teacher or specific rating scales. Some clinicians find it helpful to do both.

In addition to using an ADHD rating scale, many clinicians find it helpful to talk directly with the teacher to obtain richness beyond the rating scales. For example, ask the teacher to describe

• The child's behavior in the classroom
• The child's learning patterns
• How long the symptoms have been present
• How the symptoms affect the child's progress at school
• Ways the teacher has adapted the classroom program to help the child
• Whether other conditions contribute to or affect the symptoms

In addition, ask to see report cards and samples of the child's schoolwork, as well as any formal testing performed by school personnel.

This interview can take place over the phone or in the form of a written narrative or a paper or computer-based questionnaire.

How to score the teacher checklist:

The ADHD-specific questionnaires and rating scales also are available for teachers. These scales accurately distinguish between children with and without the diagnosis of ADHD. Whether these scales provide additional benefit beyond narratives or descriptive interviews informed by DSM-IV criteria is not known. Using scales can give an objective rating for monitoring improvements.

A corresponding teacher scale to complement the parent questionnaire has been developed. Once the form is completed, the ADHD subtype can be determined.

a. For questions 1–9, add up the number of questions where the teacher circled a 2 or 3.
b. For questions 10–18, add up the number of questions where the teacher circled a 2 or 3.
c. For questions 36–43, add up the number of questions where the teacher circled a 4 or 5.

• For Predominantly Inattentive subtype, at least 6 of questions 1–9 must score a 2 or 3. In addition, at least 1 of questions 36–43 must score a 4 or 5.
• For Predominantly Hyperactive/Impulsive subtype, at least 6 of questions 10–18 must score a 2 or 3. In addition, at least 1 of questions 36–43 must score a 4 or 5.
• For Combined Inattention/Hyperactivity subtype, at least 6 of questions 1–9 and 6 of questions 10–18 must score a 2 or 3. In addition, at least 1 of questions 36–43 must score a 4 or 5.
A treatment plan is tailored to the individual needs of the child and family. It may require medical, educational, behavioral, and psychological interventions. This multimodal approach can improve the child’s behavior in the home, classroom, and social settings. In most cases, successful treatment will include a combination of stimulant medication and behavior therapy.

The AAP clinical practice guideline, “Treatment of the School-Aged Child With Attention-Deficit/Hyperactivity Disorder,” contains the following recommendations for treatment of ADHD in children aged 6 to 12 years:

1. Primary care clinicians should establish a treatment program that recognizes ADHD as a chronic condition.
2. The treating clinician, parents, and the child, in collaboration with school personnel, should specify appropriate target outcomes to guide management.
3. The clinician should recommend stimulant medication and/or behavioral therapy as appropriate to improve target outcomes in children with ADHD.
4. When the selected management for a child with ADHD has not met target outcomes, clinicians should evaluate the original diagnosis, use of all appropriate treatments, adherence to the treatment plan, and presence of coexisting conditions.
5. The clinician should periodically provide a systematic follow-up for the child with ADHD. Monitoring should be directed to target outcomes and adverse effects by obtaining specific information from parents, teachers, and the child.

The AAP guideline recognizes the variation in severity and complexity of children presenting with ADHD and specifically limits the target population to children aged 6 to 12 years with ADHD but without major coexisting conditions.

Tools

ADHD Management Plan (2 Samples)

The ADHD Management Plan is a written handout for the child and family describing planned goals, indicating when and how to take any prescribed medications, and outlining the next steps. Its purpose is to help the child and family manage his or her ADHD.

The monitoring plan should consider normal developmental changes in behavior over time, educational expectations that increase with each grade, and the dynamic nature of a child’s home and school environment. Changes in any of these areas may alter target behaviors.

This form also can be used to monitor the date of refills, medication type, dosage, frequency, quantity, and responses to treatment (both medication and behavior therapy).

These samples are provided as a template; a clinician can adapt either version to fit his or her own practice and approach.

How to Establish a School-Home Daily Report Card

The Daily Report Card (DRC) is a form of behavior modification that can be used to reward the child for meeting specific target outcomes in home and classroom settings.

This tool follows the same concept as an academic report card, but focuses on the child’s behaviors. The DRC provides immediate feedback on the child’s behaviors. Each day, the parent fills out a DRC on the child’s behavior at home. Similarly, the teacher fills out the DRC on the child’s behavior at school and sends it home. The parent rewards the child for a good report, or withholds a privilege in the case of a bad report.

The physician will need to be familiar with these tools to assist with the implementation of the DRC by reviewing it with parents; this provides parents with the direction needed to use this tool at home and assist the teacher with its use at school. This tool provides for communication among the school, parents, and clinician so all parties involved in the child’s care know how well the child is meeting his or her target outcomes.

Stimulant Medication Management Information

Intended for use by the clinician, this tool reviews the types of stimulants available, dosing, and potential side effects. This chart will need updating at intervals as new medications are introduced.
The AAP ADHD clinical practice guidelines underscore the important role of children and families in the evaluation process as well as the design of an appropriate management plan. The following tools can facilitate the inclusion of the child and family:

Tools

Understanding ADHD: Information for Parents About Attention-Deficit/Hyperactivity Disorder
This excellent AAP booklet provides answers to many of parents’ most common questions about ADHD.

Does My Child Have ADHD?
This tool suggests parents monitor some of their child’s behaviors to facilitate the evaluation for ADHD.

Evaluating Your Child for ADHD and ADHD Evaluation Timeline
This tool includes a timeline that can help parents or caregivers understand the steps required for making a diagnosis and facilitate obtaining the necessary information.

For Parents of Children With ADHD
This list contains helpful suggestions on parenting a child with ADHD.

What Can I Do When My Child Has Problems With Sleep?
This is a handout for parents with suggestions for how to handle children with ADHD who have problems with sleep.

Educational Rights for Children With ADHD
Intended primarily for use by the clinician, this tool can be used to guide parents’ decisions about educational interventions to help children with ADHD.

Homework Tips for Parents
This list contains helpful suggestions on completing educational assignments.

Working With Your Child’s School
This is a parent education piece that provides suggestions for initiating an educational partnership, collaborating on the child’s evaluation, and cooperating throughout the child’s school career on the targeted outcomes.

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RESOURCES

Tools

**ADHD Coding Fact Sheet for Primary Care Clinicians**
This tool summarizes helpful facts to ensure appropriate coding for ADHD services.

**ADHD Encounter Form**
This is a sample billing form that a clinician can adapt for his or her practice and approach.

**Documentation for Reimbursement**
This is a sample letter that a clinician can use to document the provision of ADHD care for insurance purposes. A clinician can adapt this for his or her practice and approach.

**ADHD Resources Available on the Internet**
This is a list of Web sites of organizations and resources helpful to the family, clinician, and school.

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### NICHQ ADHD Primary Care Initial Evaluation Form

**Patient Name** ___________________________ **Date of Birth** ____________ **Date of Evaluation** ____________

**Info From:**
- ☐ Parent(s)
- ☐ Patient
- ☐ Teacher
- ☐ Current School/Grade

**Teacher Name(s)___________________________ Phone #(s) ________________

**Counselor Name(s)________________________ Phone #(s) ________________

---

### Significant Past Medical History

- ☐ Birth history
- ☐ Developmental/behavioral history
- ☐ Health history
- ☐ Family medical history
- ☐ Current medications
- ☐ Prior ADHD diagnosis and/or treatment
- ☐ Stressors

---

### Physical Examination

- Height ___________ Weight ___________ BP ___________

**HEENT/NECK:** __________________

**CHEST/COR/LUNGS:**

**ABD:**

**GU:**

**NEURO:**

**LAB/EVALUATIONS:**
- ☐ Vision
- ☐ Hearing

**NOTES:**

---

### Chief Concerns

---

### ADHD Diagnostic Assessment:

**Rating scale used?**
- ☐ Yes
- ☐ No

If yes, scale used:
- ☐ NICHQ Vanderbilt
- ☐ Other

<table>
<thead>
<tr>
<th>ADHD Subtype Score, Impairment, and Performance: <strong>Parent Report</strong></th>
<th>Total Number of Positive Symptoms</th>
<th>Criteria</th>
<th>Meets DSM-IV Criteria?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inattentive (questions 1–9); scores of 2 or 3 are positive.</td>
<td>/9</td>
<td>6/9 + 1 positive impairment score</td>
<td>☐ Y ☐ N</td>
</tr>
<tr>
<td>Hyperactive (questions 10–18); scores of 2 or 3 are positive.</td>
<td>/9</td>
<td>6/9 + 1 positive impairment score</td>
<td>☐ Y ☐ N</td>
</tr>
<tr>
<td>Combined (questions 1–18); scores of 2 or 3 are positive.</td>
<td>/18</td>
<td>12/18 + 1 positive impairment score</td>
<td>☐ Y ☐ N</td>
</tr>
<tr>
<td>Performance (questions 48–55); scores of 4 or 5 are positive.</td>
<td>/8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADHD Subtype Score, Impairment, and Performance: <strong>Teacher Report</strong></th>
<th>Total Number of Positive Symptoms</th>
<th>Criteria</th>
<th>Meets DSM-IV Criteria?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inattentive (questions 1–9); scores of 2 or 3 are positive.</td>
<td>/9</td>
<td>6/9 + 1 positive impairment score</td>
<td>☐ Y ☐ N</td>
</tr>
<tr>
<td>Hyperactive (questions 10–18); scores of 2 or 3 are positive.</td>
<td>/9</td>
<td>6/9 + 1 positive impairment score</td>
<td>☐ Y ☐ N</td>
</tr>
<tr>
<td>Combined (questions 1–18); scores of 2 or 3 are positive.</td>
<td>/18</td>
<td>12/18 + 1 positive impairment score</td>
<td>☐ Y ☐ N</td>
</tr>
<tr>
<td>Performance (questions 36–43); scores of 4 or 5 are positive.</td>
<td>/8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Symptoms present >6 months? | ☐ Y ☐ N |
| Symptoms present to some degree <7 years old? | ☐ Y ☐ N |

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Revised - 1002

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Screening for Co-morbidities

From Parent NICHQ Vanderbilt:
- **Oppositional-Defiant Disorder** is screened by 4 of 8 symptoms (scores of 2 or 3 are positive) (questions 19 through 26) AND a score of 4 or 5 on any of the 8 Performance Section items.
- **Conduct Disorder** is screened by 3 of 14 symptoms (scores of 2 or 3 are positive) (questions 27 through 40) AND a score of 4 or 5 on any of the 8 Performance Section items.
- **Anxiety/Depression** are screened by 3 of 7 symptoms (scores of 2 or 3 are positive) (questions 41 through 47) AND a score of 4 or 5 on any of the 8 Performance Section items.

From Teacher NICHQ Vanderbilt: Scores of 2 or 3 on a single item reflect *often-occurring* behaviors.
- **Oppositional-Defiant/Conduct Disorder** are screened by 3 of 10 items (scores of 2 or 3 are positive) (questions 19 through 28) AND a score of 4 or 5 on any of the 8 Performance Section items.
- **Anxiety/Depression** are screened by 3 of 7 items (scores of 2 or 3 are positive) (questions 29 through 35) AND a score of 4 or 5 on any of the 8 Performance Section items.

From Other Sources:
- Mental health problems
- Learning disabilities
- Other medical conditions

Assessment

- Does not meet criteria for ADHD.
- **Predominantly Inattentive subtype** requires 6 out of 9 symptoms (scores of 2 or 3 are positive) on items 1 through 9 AND a performance problem (scores of 4 or 5) in any of the items on the Performance Section for both the Parent and Teacher Assessment Scales.
- **Predominantly Hyperactive/Impulsive subtype** requires 6 out of 9 symptoms (scores of 2 or 3 are positive) on items 10 through 18 AND a performance problem (scores of 4 or 5) in any of the items on the Performance Section for both the Parent and Teacher Assessment Scales.
- **ADHD Combined Inattention/Hyperactivity** requires the above criteria on both Inattentive and Hyperactive/Impulsive subtypes.
- ADHD not otherwise specified.

Plan

- Patient provided with a written ADHD Management Plan

Management

Medication

Titration follow-up plan

Behavioral counseling

School

Other specialist referral

Follow-up office visit scheduled for

Goal for measurement at follow-up (specific criteria, eg, homework done, decrease school disciplinary notes)
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?

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Never</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does not pay attention to details or makes careless mistakes with, for example, homework</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Has difficulty keeping attention to what needs to be done</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Does not seem to listen when spoken to directly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Has difficulty organizing tasks and activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Is easily distracted by noises or other stimuli</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Is forgetful in daily activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Fidgets with hands or feet or squirms in seat</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Leaves seat when remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Runs about or climbs too much when remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Has difficulty playing or beginning quiet play activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Is “on the go” or often acts as if “driven by a motor”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Talks too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Blurs out answers before questions have been completed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Has difficulty waiting his or her turn</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Interrupts or intrudes in on others’ conversations and/or activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Argues with adults</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Loses temper</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. Actively defies or refuses to go along with adults’ requests or rules</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. Deliberately annoys people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. Blames others for his or her mistakes or misbehaviors</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24. Is touchy or easily annoyed by others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25. Is angry or resentful</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26. Is spiteful and wants to get even</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27. Bullies, threatens, or intimidates others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28. Starts physical fights</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29. Lies to get out of trouble or to avoid obligations (ie, “cons” others)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30. Is truant from school (skips school) without permission</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>31. Is physically cruel to people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>32. Has stolen things that have value</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
### Symptoms (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>33. Deliberately destroys others’ property</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>35. Is physically cruel to animals</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>36. Has deliberately set fires to cause damage</td>
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<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>37. Has broken into someone else's home, business, or car</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>38. Has stayed out at night without permission</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>39. Has run away from home overnight</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>40. Has forced someone into sexual activity</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>41. Is fearful, anxious, or worried</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>42. Is afraid to try new things for fear of making mistakes</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>43. Feels worthless or inferior</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>44. Blames self for problems, feels guilty</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45. Feels lonely, unwanted, or unloved; complains that “no one loves him or her”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46. Is sad, unhappy, or depressed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>47. Is self-conscious or easily embarrassed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</tbody>
</table>

### Performance

<table>
<thead>
<tr>
<th>Performance</th>
<th>Excellent</th>
<th>Above Average</th>
<th>Average</th>
<th>Somewhat of a Problem</th>
<th>Problematic</th>
</tr>
</thead>
<tbody>
<tr>
<td>48. Overall school performance</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>49. Reading</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>50. Writing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>51. Mathematics</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>52. Relationship with parents</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>53. Relationship with siblings</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>54. Relationship with peers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>55. Participation in organized activities (eg, teams)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### 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: ____________________________
### NICHQ Vanderbilt Assessment Scale—TEACHER Informant

**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
- [ ] not on medication
- [ ] not sure?

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Never</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fails to give attention to details or makes careless mistakes in schoolwork</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Has difficulty sustaining attention to tasks or activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Does not seem to listen when spoken to directly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Has difficulty organizing tasks and activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Loses things necessary for tasks or activities (school assignments, pencils, or books)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Is easily distracted by extraneous stimuli</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Is forgetful in daily activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Fidgets with hands or feet or squirms in seat</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Leaves seat in classroom or in other situations in which remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Runs about or climbs excessively in situations in which remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Has difficulty playing or engaging in leisure activities quietly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Is “on the go” or often acts as if “driven by a motor”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Talks excessively</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Blurs out answers before questions have been completed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Has difficulty waiting in line</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Interrupts or intrudes on others (eg, butts into conversations/games)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Loses temper</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Actively defies or refuses to comply with adult's requests or rules</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. Is angry or resentful</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. Is spiteful and vindictive</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. Bullies, threatens, or intimidates others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24. Initiates physical fights</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25. Lies to obtain goods for favors or to avoid obligations (eg, “cons” others)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26. Is physically cruel to people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27. Has stolen items of nontrivial value</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28. Deliberately destroys others’ property</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29. Is fearful, anxious, or worried</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30. Is self-conscious or easily embarrassed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>31. Is afraid to try new things for fear of making mistakes</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</tbody>
</table>

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

National Initiative for Children's Healthcare Quality

McNeil
Teacher’s Name: ______________________________  Class Time: __________________  Class Name/Period: _______________

Today’s Date: ___________  Child’s Name: ______________________________  Grade Level: ______________________________

**Symptoms (continued)**

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Never</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>32.</td>
<td>Feels worthless or inferior</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>33.</td>
<td>Blames self for problems; feels guilty</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>34.</td>
<td>Feels lonely, unwanted, or unloved; complains that “no one loves him or her”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>35.</td>
<td>Is sad, unhappy, or depressed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Performance Academic Performance**

<table>
<thead>
<tr>
<th>Subject</th>
<th>Excellent</th>
<th>Above Average</th>
<th>Average</th>
<th>Problem</th>
<th>Problematic</th>
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</thead>
<tbody>
<tr>
<td>36. Reading</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>37. Math</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>38. Written expression</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</table>

**Classroom Behavioral Performance**

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Excellent</th>
<th>Above Average</th>
<th>Average</th>
<th>Problem</th>
<th>Problematic</th>
</tr>
</thead>
<tbody>
<tr>
<td>39. Relationship with peers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>40. Following directions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>41. Disrupting class</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>42. Assignment completion</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>43. Organizational skills</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

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: __________________________
**NICHQ Vanderbilt Assessment Follow-up—PARENT Informant**

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. Please think about your child’s behaviors since the last assessment scale was filled out when rating his/her behaviors.

Is this evaluation based on a time when the child  □ was on medication  □ was not on medication  □ not sure?

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Never</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does not pay attention to details or makes careless mistakes with,</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>for example, homework</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Has difficulty keeping attention to what needs to be done</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Does not seem to listen when spoken to directly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Does not follow through when given directions and fails to</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>finish activities (not due to refusal or failure to understand)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Has difficulty organizing tasks and activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Avoids, dislikes, or does not want to start tasks that require</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>ongoing mental effort</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Loses things necessary for tasks or activities (toys, assignments,</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>pencils, or books)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Is easily distracted by noises or other stimuli</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Is forgetful in daily activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Fidgets with hands or feet or squirms in seat</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Leaves seat when remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Runs about or climbs too much when remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Has difficulty playing or beginning quiet play activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Is “on the go” or often acts as if “driven by a motor”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Talks too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Blurs out answers before questions have been completed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Has difficulty waiting his or her turn</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Interrupts or intrudes in on others’ conversations and/or activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance</th>
<th>Excellent</th>
<th>Above Average</th>
<th>Average</th>
<th>Somewhat of a Problem</th>
<th>Problematic</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. Overall school performance</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20. Reading</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21. Writing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22. Mathematics</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>23. Relationship with parents</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24. Relationship with siblings</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25. Relationship with peers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26. Participation in organized activities (eg, teams)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

McNeil

National Initiative for Children’s Healthcare Quality

HI0352
### Side Effects: Has your child experienced any of the following side effects or problems in the past week?

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Are these side effects currently a problem?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>None</td>
</tr>
<tr>
<td>Stomachache</td>
<td></td>
</tr>
<tr>
<td>Change of appetite—explain below</td>
<td></td>
</tr>
<tr>
<td>Trouble sleeping</td>
<td></td>
</tr>
<tr>
<td>Irritability in the late morning, late afternoon, or evening—explain below</td>
<td></td>
</tr>
<tr>
<td>Socially withdrawn—decreased interaction with others</td>
<td></td>
</tr>
<tr>
<td>Extreme sadness or unusual crying</td>
<td></td>
</tr>
<tr>
<td>Dull, tired, listless behavior</td>
<td></td>
</tr>
<tr>
<td>Tremors/feeling shaky</td>
<td></td>
</tr>
<tr>
<td>Repetitive movements, tics, jerking, twitching, eye blinking—explain below</td>
<td></td>
</tr>
<tr>
<td>Picking at skin or fingers, nail biting, lip or cheek chewing—explain below</td>
<td></td>
</tr>
<tr>
<td>Sees or hears things that aren’t there</td>
<td></td>
</tr>
</tbody>
</table>

### Explain/Comments:

---

**For Office Use Only**

Total Symptom Score for questions 1–18:

Average Performance Score for questions 19–26:

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.
**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 last assessment scale was filled out. 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

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Never</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does not pay attention to details or makes careless mistakes with, for example, homework</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Has difficulty keeping attention to what needs to be done</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Does not seem to listen when spoken to directly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Has difficulty organizing tasks and activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Is easily distracted by noises or other stimuli</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Is forgetful in daily activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Fidgets with hands or feet or squirms in seat</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Leaves seat when remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Runs about or climbs too much when remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Has difficulty playing or beginning quiet play activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Is “on the go” or often acts as if “driven by a motor”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Talks too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Blurs out answers before questions have been completed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Has difficulty waiting his or her turn</td>
<td>0</td>
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<td>3</td>
</tr>
<tr>
<td>18. Interrupts or intrudes in on others’ conversations and/or activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance</th>
<th>Excellent</th>
<th>Average</th>
<th>Average</th>
<th>Somewhat of a Problem</th>
<th>Problematic</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. Reading</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20. Mathematics</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21. Written expression</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22. Relationship with peers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>23. Following direction</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24. Disrupting class</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25. Assignment completion</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26. Organizational skills</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.
**D6  NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant, continued**

Teacher’s Name: _______________________________  Class Time: _______________  Class Name/Period: _______________

Today’s Date: ___________  Child’s Name: _______________________________  Grade Level: _______________

Please return this form to: __________________________________________________________________________________

Mailing address: __________________________________________________________________________________________

________________________________________________________________________________________________________

Fax number: ____________________________________________________________________________________________

### Side Effects:

Has the child experienced any of the following side effects or problems in the past week?

<table>
<thead>
<tr>
<th>Side Effects</th>
<th>Are these side effects currently a problem?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>None</td>
</tr>
<tr>
<td>Stomachache</td>
<td></td>
</tr>
<tr>
<td>Change of appetite—explain below</td>
<td></td>
</tr>
<tr>
<td>Trouble sleeping</td>
<td></td>
</tr>
<tr>
<td>Irritability in the late morning, late afternoon, or evening—explain below</td>
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<tr>
<td>Socially withdrawn—decreased interaction with others</td>
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</tr>
<tr>
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<tr>
<td>Repetitive movements, tics, jerking, twitching, eye blinking—explain below</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>Sees or hears things that aren’t there</td>
<td></td>
</tr>
</tbody>
</table>

**Explain/Comments:**

---

**For Office Use Only**

Total Symptom Score for questions 1–18: ____________________________________

Average Performance Score: ______________________________________________

---

Please return this form to: __________________________________________________________________________________

Mailing address: __________________________________________________________________________________________

________________________________________________________________________________________________________

Fax number: ____________________________________________________________________________________________

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

American Academy of Pediatrics  
Dedicated to the Health of All Children®

NICHQ: National Initiative for Children’s Healthcare Quality

McNeil  

11-22/rev0303
Scoring Instructions for the NICHQ Vanderbilt Assessment Scales

These scales should NOT be used alone to make any diagnosis. You must take into consideration information from multiple sources. Scores of 2 or 3 on a single Symptom question reflect often-occurring behaviors. Scores of 4 or 5 on Performance questions reflect problems in performance.

The initial assessment scales, parent and teacher, have 2 components: symptom assessment and impairment in performance. On both the parent and teacher initial scales, the symptom assessment screens for symptoms that meet criteria for both inattentive (items 1–9) and hyperactive ADHD (items 10–18).

To meet DSM-IV criteria for the diagnosis, one must have at least 6 positive responses to either the inattentive or hyperactive 9 core symptoms, or both. A positive response is a 2 or 3 (often, very often) (you could draw a line straight down the page and count the positive answers in each subsegment). There is a place to record the number of positives in each subsegment, and a place for total score for the first 18 symptoms (just add them up).

The initial scales also have symptom screens for 3 other co-morbidities—oppositional-defiant, conduct, and anxiety/depression. These are screened by the number of positive responses in each of the segments separated by the “squares.” The specific item sets and numbers of positives required for each co-morbid symptom screen set are detailed below.

The second section of the scale has a set of performance measures, scored 1 to 5, with 4 and 5 being somewhat of a problem/problematic. To meet criteria for ADHD there must be at least one item of the Performance set in which the child scores a 4 or 5; ie, there must be impairment, not just symptoms to meet diagnostic criteria. The sheet has a place to record the number of positives (4s, 5s) and an Average Performance Score—add them up and divide by number of Performance criteria answered.

<table>
<thead>
<tr>
<th>Parent Assessment Scale</th>
<th>Teacher Assessment Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Predominantly Inattentive subtype</strong></td>
<td><strong>Predominantly Inattentive subtype</strong></td>
</tr>
<tr>
<td>Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND</td>
<td>Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND</td>
</tr>
<tr>
<td>Score a 4 or 5 on any of the Performance questions 48–55</td>
<td>Score a 4 or 5 on any of the Performance questions 36–43</td>
</tr>
<tr>
<td><strong>Predominantly Hyperactive/Impulsive subtype</strong></td>
<td><strong>Predominantly Hyperactive/Impulsive subtype</strong></td>
</tr>
<tr>
<td>Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND</td>
<td>Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND</td>
</tr>
<tr>
<td>Score a 4 or 5 on any of the Performance questions 48–55</td>
<td>Score a 4 or 5 on any of the Performance questions 36–43</td>
</tr>
<tr>
<td><strong>ADHD Combined Inattention/Hyperactivity</strong></td>
<td><strong>ADHD Combined Inattention/Hyperactivity</strong></td>
</tr>
<tr>
<td>Requires the above criteria on both inattention and hyperactivity/impulsivity</td>
<td>Requires the above criteria on both inattention and hyperactivity/impulsivity</td>
</tr>
<tr>
<td><strong>Oppositional-Defiant Disorder Screen</strong></td>
<td><strong>Oppositional-Defiant/Conduct Disorder Screen</strong></td>
</tr>
<tr>
<td>Must score a 2 or 3 on 4 out of 8 behaviors on questions 19–26 AND</td>
<td>Must score a 2 or 3 on 3 out of 10 items on questions 19–28 AND</td>
</tr>
<tr>
<td>Score a 4 or 5 on any of the Performance questions 48–55</td>
<td>Score a 4 or 5 on any of the Performance questions 36–43</td>
</tr>
<tr>
<td><strong>Conduct Disorder Screen</strong></td>
<td><strong>Conduct Disorder Screen</strong></td>
</tr>
<tr>
<td>Must score a 2 or 3 on 3 out of 14 behaviors on questions 27–40 AND</td>
<td>Must score a 2 or 3 on 3 out of 7 items on questions 29–35 AND</td>
</tr>
<tr>
<td>Score a 4 or 5 on any of the Performance questions 48–55</td>
<td>Score a 4 or 5 on any of the Performance questions 36–43</td>
</tr>
<tr>
<td><strong>Anxiety/Depression Screen</strong></td>
<td><strong>Anxiety/Depression Screen</strong></td>
</tr>
<tr>
<td>Must score a 2 or 3 on 3 out of 7 behaviors on questions 41–47 AND</td>
<td>Must score a 2 or 3 on 3 out of 7 items on questions 29–35 AND</td>
</tr>
<tr>
<td>Score a 4 or 5 on any of the Performance questions 48–55</td>
<td>Score a 4 or 5 on any of the Performance questions 36–43</td>
</tr>
</tbody>
</table>

The average of the Performance items answered as measures of improvement over time with treatment.

Parent Assessment Follow-up
- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.

Teacher Assessment Follow-up
- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.
**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?

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Never</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not pay attention to details or makes careless mistakes with, for example, homework</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Has difficulty keeping attention to what needs to be done</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Does not seem to listen when spoken to directly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Has difficulty organizing tasks and activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Avoids, dislikes, or does not want to start tasks that require ongoing mental effort</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Loses things necessary for tasks or activities (toys, assignments, pencils, or books)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Is easily distracted by noises or other stimuli</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Is forgetful in daily activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Fidgets with hands or feet or squirms in seat</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Leaves seat when remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Runs about or climbs too much when remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Has difficulty playing or beginning quiet play activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Is “on the go” or often acts as if “driven by a motor”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Talks too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Blurs out answers before questions have been completed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Has difficulty waiting his or her turn</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Interrupts or intrudes in on others’ conversations and/or activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Argues with adults</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Loses temper</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Actively defies or refuses to go along with adults’ requests or rules</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Deliberately annoys people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Blames others for his or her mistakes or misbehaviors</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Is touchy or easily annoyed by others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Is angry or resentful</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Is spiteful and wants to get even</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Bullies, threatens, or intimidates others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Starts physical fights</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Lies to get out of trouble or to avoid obligations (ie, “cons” others)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Is truant from school (skips school) without permission</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Is physically cruel to people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Has stolen things that have value</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Deliberately destroys others’ property</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
## NICHQ Vanderbilt Assessment Scale—PARENT Informant

### Today's Date: **4-7-02**  
Child's Name: **John Doe**  
Date of Birth: **10-18-94**

Parent's Name: **Jane and Louis Doe**  
Parent's Phone Number: **555-1212**

### 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 (continued)

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>35. Is physically cruel to animals</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>36. Has deliberately set fires to cause damage</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>37. Has broken into someone else's home, business, or car</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>38. Has stayed out at night without permission</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>39. Has run away from home overnight</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>40. Has forced someone into sexual activity</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>41. Is fearful, anxious, or worried</td>
<td>0</td>
<td>(1)</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>42. Is afraid to try new things for fear of making mistakes</td>
<td>0</td>
<td>(1)</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>43. Feels worthless or inferior</td>
<td>0</td>
<td>(1)</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>44. Blames self for problems, feels guilty</td>
<td>0</td>
<td>(1)</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45. Feels lonely, unwanted, or unloved; complains that “no one loves him or her”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46. Is sad, unhappy, or depressed</td>
<td>0</td>
<td>(1)</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>47. Is self-conscious or easily embarrassed</td>
<td>0</td>
<td>(1)</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

### Performance

<table>
<thead>
<tr>
<th>Performance</th>
<th>Excellent</th>
<th>Above Average</th>
<th>Average</th>
<th>Somewhat of a Problem</th>
<th>Problematic</th>
</tr>
</thead>
<tbody>
<tr>
<td>48. Overall school performance</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>49. Reading</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>50. Writing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>51. Mathematics</td>
<td>1</td>
<td>2</td>
<td>(3)</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>52. Relationship with parents</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>53. Relationship with siblings</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>54. Relationship with peers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>55. Participation in organized activities (eg, teams)</td>
<td>1</td>
<td>2</td>
<td>(3)</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### Comments:

For Office Use Only

<table>
<thead>
<tr>
<th>Total number of questions scored 2 or 3 in questions 1–9:</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of questions scored 2 or 3 in questions 10–18:</td>
<td>7</td>
</tr>
<tr>
<td>Total Symptom Score for questions 1–18:</td>
<td>39</td>
</tr>
<tr>
<td>Total number of questions scored 2 or 3 in questions 19–26:</td>
<td>0</td>
</tr>
<tr>
<td>Total number of questions scored 2 or 3 in questions 27–40:</td>
<td>0</td>
</tr>
<tr>
<td>Total number of questions scored 2 or 3 in questions 41–47:</td>
<td>0</td>
</tr>
<tr>
<td>Total number of questions scored 4 or 5 in questions 48–55:</td>
<td>6</td>
</tr>
<tr>
<td>Average Performance Score:</td>
<td>3.9</td>
</tr>
</tbody>
</table>

Physician Note: John Doe met DSM criteria for ADHD Combined Inattention/Hyperactivity.
Dear Teacher:

The parents of one of your students are seeking to have their child evaluated by our office for a health concern. As part of our evaluation process, we ask that both the child's parents and teacher complete a set of behavioral rating scales. This information is important for the diagnosis and treatment of your student.

**Your time and cooperation in this matter is greatly appreciated.** Attached please find a Release of Information Form that the parents have completed and a set of teacher rating scales and questionnaires. These forms include:

1. NICHQ Vanderbilt Teacher Assessment Scale
2. ________________________________________
3. ________________________________________
4. ________________________________________

**Generally, the teacher who spends the most time with the child should complete the teacher rating scales.** However, if the child has more than one primary teacher, or has a special education teacher, it would be useful for us to obtain a separate set of rating scales from each teacher. If more than one set of rating scales is required, please have the parent contact us directly at _____________ and we will forward additional rating scales as needed. Please note that the same teacher should complete each entire set of forms.

Please fill out the forms as completely as possible. If you do not know the answer to a question, please write, "Don't know," so that we can be sure the item was not simply overlooked. Some of the questions in the rating scales may seem redundant. This is necessary to ensure that we obtain accurate diagnostic information.

**We ask that you complete these forms as soon as possible,** as we are unable to begin a child's evaluation without the teacher rating scales. **The forms should be mailed to us directly in the envelope provided.**

Thank you for your assistance and cooperation in the completion of these forms. If you have any questions regarding the enclosed materials, or if you would like additional information regarding services provided, please do not hesitate to contact us.

Sincerely,

John Doe, M.D
Clinical Director
Pediatric Clinic
Pediatric Clinic Address
Pediatric Clinic Phone Number
Pediatric Clinic Fax Number

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**ADHD Management Plan—Sample 1**

Date: ________________

To the family of ____________________________________________, please refer to this plan between visits if you have questions about care. If you are still unsure, call us at ______________________ for assistance.

| Patient ____________________________’s doctor is ____________________________ Pager # ____________ |
|--------------------------------------|----------------------------------|
| Parent/Guardian ________________________ Relationship ____________________________ |
| Contact Number(s) ____________________ |                                  |
| School Name __________________________ School Phone No. __________ Fax No. ____________ |
| Key Teacher Contact Name ______________ | Grade __________ Teacher’s Email Address ____________________________ |

**Goals** What improvements would you most like to see? Specific behavior you would like to see improve:

At Home:

At School:

**Plans** to reach these goals:

1. ___________________________________________
2. ___________________________________________
3. ___________________________________________

**Medication**

<table>
<thead>
<tr>
<th>1. ____________________________</th>
<th>Time____ am/pm</th>
<th>Time____ am/pm</th>
<th>Time____ am/pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose 1____ mg</td>
<td>Dose 2____ mg</td>
<td>Dose 3____ mg</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. ____________________________</th>
<th>Time____ am/pm</th>
<th>Time____ am/pm</th>
<th>Time____ am/pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose 1____ mg</td>
<td>Dose 2____ mg</td>
<td>Dose 3____ mg</td>
<td></td>
</tr>
</tbody>
</table>

☐ Medication to be given on nonschool days  ☐ Medication given for ________ number of days
☐ School authorization signed by parent and MD  ☐ Rx written for duplicate bottle for administration at school
☐ Side effects explained/information given

**Common Side Effects**: decreased appetite, sleep problems, transient stomachache, transient headache, behavioral rebound

**Call your doctor immediately if any infrequent side effects occur**: weight loss, increased heart rate and/or blood pressure, dizziness, growth suppression, hallucinations/mania, exacerbation of tics and Tourette syndrome (rare)

**Further Evaluation**

☐ School testing scheduled date ____________________________

☐ Parent and Teacher Vanderbilt completed ____________________

**Additional Resources and Treatment Strategies**

☐ F/U Parent Vanderbilt given completed ____________________

☐ F/U Teacher Vanderbilt given to parent completed ____________________

☐ F/U Teacher Vanderbilt to be faxed to school completed ____________________

☐ Behavioral Modification Counseling Referral to completed ____________________

☐ Parenting Tips Sheet given CHADD phone number given: 800/233-4050

☐ Community Resources/Referrals: ____________________________

**Next Follow-up Visit**: ____________________________
ADHD Management Plan—Sample 2

Patient __________________________’s doctor is ____________________________ Pager # __________

Parent/Guardian __________________________ Relationship __________________________

Contact Number(s) __________________________

School Name __________________________ School Phone No. __________________________

Key Teacher Contact Name __________ Grade Level __________
Teacher’s E-mail Address __________________________ Fax No. __________________________

**Goals**  What improvements would you most like to see?

1. __________

2. __________

3. __________

**Plans**  to reach these goals:

1. __________

2. __________

3. __________

**Medication**

1. __________ Time ______ am/pm Time ______ am/pm Time ______ am/pm

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose</td>
<td>mg</td>
<td>Dose</td>
</tr>
<tr>
<td>1</td>
<td>mg</td>
<td>2</td>
</tr>
</tbody>
</table>

2. __________ Time ______ am/pm Time ______ am/pm Time ______ am/pm

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose</td>
<td>mg</td>
<td>Dose</td>
</tr>
<tr>
<td>1</td>
<td>mg</td>
<td>2</td>
</tr>
</tbody>
</table>

**Further Evaluation**

☐ Parent Assessment received and follow-up appointment scheduled for ___/___/____

☐ Teacher Assessment will be done by Ms/Mr __________________________

☐ School testing scheduled on this date ___/___/____

**Additional Resources and Treatment Strategies**

☐ Behavioral Modification Counseling Referral to __________

☐ Parenting Tips Sheet given

☐ Parent Follow-up form completed ___/___/____

☐ Teacher Follow-up form completed ___/___/____

☐ CHADD phone number given: 800/233-4050

**Common Side Effects**  If Any Infrequent Side Effects Occur, Call Your Doctor Immediately!

- Decreased appetite
- Sleep problems
- Transient headache
- Transient stomachache
- Behavioral rebound

- Weight loss
- Increased heart rate and/or blood pressure
- Dizziness
- Growth suppression
- Hallucinations/mania
- Exacerbation of tics and Tourette syndrome (rare)

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American Academy of Pediatrics

National Initiative for Children’s Healthcare Quality
How to Establish a School-Home Daily Report Card

1. Select the Areas for Improvement.
   - Discuss the child’s behavior with all school staff who work with the child.
   - Determine the child’s greatest areas of impairment.
   - Define goals toward which the child should be working regarding the areas of impairment.
   - Key domains:
     - Improving peer relations
     - Improving academic work
     - Improving classroom rule-following and relationships with adults

   - Identify specific behaviors (“target behaviors”) that can be changed to make progress toward the goals easier.
   - Target behaviors must be meaningful and clearly defined/observed/counted by teacher and child.
   - Examples of target behaviors in the key domains:
     - Improving peer relations: does not interrupt other children during their work time, does not tease other children, plays without fighting at recess
     - Improving academic work: has materials and assignments necessary to do tasks, completes assigned academic tasks, is accurate on assigned tasks, completes and returns homework
     - Improving classroom rule-following and relationships with adults: obeys the teacher when commands are given, does not talk back to the teacher, follows classroom rules
   - Additional target behaviors are listed on the attached sheet, Sample Report Card Targets.

   - Estimate how often the child is doing the target behaviors by reviewing school records and/or observation.
   - Determine which behaviors need to be included on the report.
   - Evaluate target behaviors several times throughout the day.
   - Set a reasonable criterion for each target behavior (a criterion is a target level the child will have to meet to receive a positive mark for that behavior). Set criteria to be met for each part of the day, not the overall day (eg, “interrupts fewer than 2 times in each class period” rather than “interrupts fewer than 12 times per day”).

   - Meet with teacher, parents, and child.
   - Explain all aspects of the Daily Report Card (DRC) to the child in a positive manner.

5. Establish a Home-based Reward System.
   - Rewards must be selected by the child.
   - Arrange awards so that:
     - Fewer or less preferred rewards can be earned for fewer yeses.
     - More desired rewards can be earned for better performance.
   - Give the child a menu of rewards (see Sample Home and School Rewards):
     - Select rewards for each level.
     - Label the different levels with child-appropriate names (eg, One-Star Day, Two-Star Day).
   - Use the Weekly Daily Report Card Chart to track weekly performance.
   - Some children need more immediate rewards than the end-of-day home rewards—in such cases, in-school rewards can be used.

6. Monitor and Modify the Programs.
   - Record daily the number of yeses the child received on each target.
   - Once the child has regularly begun to meet the criterion, make the criteria harder (if the child is regularly failing to meet the criterion, make the criteria easier).
   - Once the criterion for a target is at an acceptable level and the child is consistently reaching it, drop that target behavior from the DRC. (Let the child know why it was dropped and replace with another target if necessary.)
   - Move to a weekly report/reward system if the child is doing so well that daily reports are no longer necessary.
   - The report card can be stopped when the child is functioning within an appropriate range within the classroom, and reinitiated if problems begin to occur again.

   - If the system is not working to change the child’s behavior, examine the program and change where appropriate (see Troubleshooting a Daily Report Card).

8. Consider Other Treatments.
   - If, after troubleshooting and modification, the DRC is not resulting in maximal improvement, consider additional behavioral components (eg, more frequent praise, time-out) and/or more powerful or intensive behavioral procedures (eg, a point system).

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American Academy of Pediatrics
National Initiative for Children's Healthcare Quality

McNeil

DEDICATED TO THE HEALTH OF ALL CHILDREN®
### Troubleshooting a Daily Report Card

<table>
<thead>
<tr>
<th>Problem</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the child taking the Daily Report Card (DRC) home?</td>
<td>Ensure that the child has a backpack or special folder in which to carry DRC. Have the teacher for last class of the day prompt the child to take DRC home. Assume the child received a negative report if he or she does not have DRC. Implement positive consequences for bringing home DRC.</td>
</tr>
<tr>
<td>Are the target behaviors appropriate?</td>
<td>Redefine the target behaviors for the child. Modify the target behaviors. Modify the target behaviors or class context (e.g., “gets along with peers” should not be a target if the class structure does not provide the opportunity for peer interactions).</td>
</tr>
<tr>
<td>Are the criteria for success realistic (e.g., not too high or too low relative to baseline)?</td>
<td>Modify the criteria to shape the behavior.</td>
</tr>
<tr>
<td>Is something interfering with the child’s reaching the criteria (e.g., child does not complete assignments due to messy, disorganized desk)?</td>
<td>Work on removing the impediment (e.g., work on improving organizational skills, modify class schedule or structure).</td>
</tr>
<tr>
<td>Does the child understand the system?</td>
<td>Implement a system of visual prompts, if necessary. Review system with child until child can accurately describe the DRC system to the child again. Simplify the DRC system if necessary.</td>
</tr>
<tr>
<td>Can the child accurately describe the target behaviors and criteria for positive evaluations?</td>
<td>Design and implement a monitoring system that includes a recording form for the child (may include visual or auditory prompts).</td>
</tr>
<tr>
<td>Can the child accurately describe the relationship between the criteria and the rewards?</td>
<td>Modify the teacher’s procedures for providing feedback to the child (e.g., provide visual prompts; increase immediacy, frequency, or contingent nature of feedback).</td>
</tr>
<tr>
<td>Is the monitoring system working properly?</td>
<td>Change the home-based rewards (e.g., increase the number of choices on menu, change the hierarchy of rewards). Review reward procedures with parents again and ensure that reward is provided only when the child has earned it.</td>
</tr>
<tr>
<td>Is the child receiving sufficient feedback so that he or she knows where he or she stands regarding the criteria?</td>
<td>Design and implement procedures for providing school-based rewards. Modify the procedures for delivering the home-based rewards (e.g., visual prompts) or the nature of the home-based rewards.</td>
</tr>
</tbody>
</table>

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# How to Establish a School-Home Daily Report Card

## Daily Home Report Card

**Circle Y (Yes) or N (No)**

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Medication</th>
<th>Week/Month</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>2.</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>3.</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>4.</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>5.</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>6.</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>7.</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>

**Total number of Yess**

**Total number of Nos**

**Comments:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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## Daily School Report Card

**Circle Y (Yes) or N (No)**

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Medication</th>
<th>Today's Date</th>
</tr>
</thead>
</table>

### Subjects/Times

<table>
<thead>
<tr>
<th>1.</th>
<th>Y</th>
<th>N</th>
<th>Y</th>
<th>N</th>
<th>Y</th>
<th>N</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>3.</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>4.</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>5.</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>6.</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>7.</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

### Teacher's Initials

| Total number of Yeses | Total number of Nos |

### Comments:

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

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National Initiative for Children’s Healthcare Quality

[Logo]
Sample Report Card Targets

**Academic Productivity**
Compltes X assignments within the specified time
Completes X assignments with X% accuracy
Starts work with X or fewer reminders
Leaves appropriate spaces between words X% of the time or assignment
Writes legibly/uses 1-line cross outs instead of scribbles/writes on the lines of the paper
Corrects assignments appropriately*
Turns in assignments appropriately*

**Following Classroom Rules**
Follows class/school rules with X or fewer violations
Interrupts class less than X times per period/Works quietly with X or fewer reminders/Makes X or fewer inappropriate noises
Follows directions with X or fewer repetitions
Stays on task with X or fewer reminders
Sits appropriately* in assigned area with X or fewer reminders
Raises hand to speak with X or fewer reminders
Uses materials or possessions appropriately*
Has XX or fewer instances of stealing
Has XX or fewer instances of cursing
Has XX or fewer instances of complaining/crying/whining
Has XX or fewer instances of lying
Has XX or fewer instances of destroying property

**Peer Relationships**
Shares/helps peers when appropriate with X or fewer reminders
Ignores negative behavior of others/Child shows no observable response to negative behavior of others
Teases peers X or fewer times per period
Fewer than X fights with peers
Speaks clearly (fewer than X prompts for mumbling)
Contributes to discussion (answers X questions orally)
Contributes to discussion (at least X unprompted, relevant, nonredundant contributions)
Fewer than X negative self comments
Minds own business with XX or fewer reminders
Needs XX or fewer reminders to stop bossing peers
Does not bother other children during seat work (fewer than X complaints from others)

**Teacher Relationships**
Accepts feedback appropriately* (no more than X arguments/ X% of arguments) following feedback

**Behavior Outside the Classroom**
Follows rules at lunch/recess/free time/gym/specials/assemblies/bathroom/in hallway with X or fewer rule violations
Walks in line appropriately*/Follows transition rules with X or fewer violations
Follows rules of the bus with X or fewer violations
Needs XX or fewer warnings for exhibiting bad table manners (eg, playing with food, chewing with mouth open, throwing trash on the floor)
Changes into gym clothes/school clothes within X:XX minutes

**Time-out Behavior**
Serves time-outs appropriately*
Child serves a time-out without engaging in inappropriate behaviors
While serving a time-out, the child exhibits no more than X instances of negative behavior

**Responsibility for Belongings**
Brings DRC to teacher for feedback before leaving for the next class/activity
Responsible for own belongings (has belongings at appropriate* times according to the checklist/chart**)
Has materials necessary for class/subject area
Organizes materials and possessions according to checklist/chart**
Morning routine completed according to checklist/chart**
End of day routine completed appropriately according to checklist/chart**
Brings supplies to class with XX or fewer reminders/brings supplies to class according to checklist/chart**
Hangs up jacket/backpack with XX or fewer reminders
Takes lunchtime pill with X or fewer reminders
Has only materials needed for the assignment on desk

**Homework**
Brings completed homework to class
Writes homework in assignment book with X or fewer reminders
DRC is returned signed the next day by parent
Has all needed materials for homework in backpack at the end of the day

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**“ Appropriately” must always be defined by teacher for child.**

**Checklist/chart must accompany target behavior and be displayed for child.**

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The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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National Initiative for Children’s Healthcare Quality
How to Establish a School-Home Daily Report Card

Sample Home Rewards

**Daily Rewards**
- Snacks
- Dessert after dinner
- Staying up X minutes beyond bedtime
- Having a bedtime story/Reading with a parent for X minutes
- Choosing a radio station in car
- Extra bathtub time for X minutes
- Educational games on computer for X minutes
- Choosing family TV show
- Talking on phone to friend (local call)
- Video game time for X minutes
- Playing outside for X minutes
- Television time for X minutes
- Listening to radio/stereo for X minutes
- Other as suggested by child

**Daily or Weekly Rewards**
- Going over to a friend's house to play
- Having a friend come over to play
- Allowance
- Bike riding/skating/scooter/skateboarding (in neighborhood for daily reward; longer trip with family or at bike trail/skate park for weekly reward)
- Special activity with mom or dad
- Special time with mom or dad for X minutes
- Earn day off from chores
- Game of choice with parent/family
- Other as suggested by child

**Weekly Rewards**
- Making a long-distance call to relatives or friends
- Going to the video arcade at the mall
- Going fishing
- Going shopping going to the mall
- Going to the movies
- Going to the park
- Getting ice cream
- Bowling, miniature golf/Selecting something special at the store
- Making popcorn
- Having friend over to spend night
- Going to friend's to spend night
- Choosing family movie
- Renting movie video
- Going to a fast-food restaurant with parent and/or family
- Watching taped TV shows
- Free time for X minutes
- Other as suggested by child

**Notes:** Older children could save over weeks to get a monthly (or longer) reward as long as visuals (eg, pieces of picture of activity) are used; eg, camping trip with parent, trip to baseball game, purchase of a video game. Rewards for an individual child need to be established as a menu. Children may make multiple choices from the menu for higher levels of reward, or may choose a longer period of time for a given reward.

Sample School Rewards*

- Talk to best friend
- Listen to tape player (with headphones)
- Read a book
- Help clean up classroom
- Clean the erasers
- Wash the chalkboard
- Be teacher's helper
- Eat lunch outside on a nice day
- Extra time at recess
- Write on chalkboard
- Use magic markers
- Draw a picture
- Choose book to read to the class
- Read to a friend
- Read with a friend
- Care for class animals
- Play "teacher"
- See a movie/filmstrip
- Decorate bulletin board
- Be messenger for office
- Grade papers
- Have treats
- Earn class party
- Class field trip
- Student of the Day/Month
- Pop popcorn
- Be a line leader
- Visit the janitor
- Use the computer
- Make ice cream sundaes
- Teach a classmate
- Choose stickers
- Take a good note home
- Receive a positive phone call
- Give lots of praise
- Hide a special note in desk
- Choose seat for specific time
- Play card games
- Receive award certificate
- Take Polaroid pictures
- Draw from "grab bag"
- Eat at a special table
- Visit the principal

*Sample School Rewards can be added to the home-based reward system especially if a child is not responding appropriately to the Home Rewards. Teachers need to make sure that a child wants and will work for one of these School Rewards.

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NICHQ: National Initiative for Children’s Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals
## Medication Management Information

Stimulant medication and dosage: Based on the patient’s daily schedule and response to medication. Measure at baseline and periodically monitor: Height, weight, blood pressure, pulse, sleep, appetite, mood, tics, family goals, and side effects.

### Stimulant Medications - Immediate Release

<table>
<thead>
<tr>
<th>Active Ingredient</th>
<th>Drug Name</th>
<th>Dosing</th>
<th>Duration of Behavioral Effects*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed salts of amphetamine (Dextroamphetamine/Levoamphetamine)</td>
<td>• Adderall Tablets (scored): 5 mg (blue), 10 mg (blue), 20 mg (pink), and 30 mg (pink)</td>
<td>Start with 5 mg 1–2 times per day and increase by 5 mg each week until good control achieved. Maximum Recommended Daily Dose: 40 mg</td>
<td>About 4–6 hours depending on dose</td>
</tr>
<tr>
<td></td>
<td>• Dextroamphetamine Tablet: 5 mg (orange)</td>
<td>Tablet: Start with 5 mg 1–2 times per day and increase by 5 mg each week until good control achieved. Maximum Recommended Daily Dose: 40 mg</td>
<td>Tablet: 4–5 hours</td>
</tr>
<tr>
<td></td>
<td>• Dextrostat Tablet (scored): 5 mg (yellow) and 10 mg (yellow)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dextroamphetamine</td>
<td>• Ritalin Tablets (scored): 5, 10, and 20 mg</td>
<td>Start with 5 mg (2.5 mg for Focalin) 1–2 times per day and increase by 5 mg each week until good control is achieved. May need third reduced dose in the afternoon. Maximum Recommended Daily Dose: 60 mg</td>
<td>3–4 hours</td>
</tr>
<tr>
<td></td>
<td>• Methylphenidate Tablets (scored): 5, 10, and 20 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methylphenidate</td>
<td>• Dextedrine Tablets: 5 mg (orange)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Dextrostat Tablet (scored): 5, 10, and 20 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Focalin Tablets: 2.5, 5, and 10 mg</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Stimulant Medications Sustained Release, continued on side 2

<table>
<thead>
<tr>
<th>Active Ingredient</th>
<th>Drug Name</th>
<th>Dosing</th>
<th>Duration of Behavioral Effects*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed salts of amphetamine (Dextroamphetamine/Levoamphetamine)</td>
<td>• Adderall XR Capsule (can be sprinkled): 10 mg (blue/blue), 20 mg (orange/orange), and 30 mg (natural/orange)</td>
<td>Start at 10 mg in the morning and increase by 10 mg each week until good control is achieved. Maximum Recommended Daily Dose: 40 mg</td>
<td>8–12 hours</td>
</tr>
<tr>
<td></td>
<td>• Dextroamphetamine Spansule Spansule (can be sprinkled): 5, 10, and 15 mg (orange/black)</td>
<td>Start at 5 mg in the morning and increase by 5 mg each week until good control is achieved. Maximum Recommended Daily Dose: 45 mg</td>
<td>8–10 hours</td>
</tr>
<tr>
<td>Dextroamphetamine</td>
<td>• Concerta Capsule (noncrushable): 18, 27, 36, and 54 mg</td>
<td>Start at 18 mg each morning and increase by 18 mg each week until good control is achieved. Maximum Recommended Daily Dose: 72 mg</td>
<td>8–12 hours</td>
</tr>
<tr>
<td></td>
<td>• Ritalin SR Tablet: 20 mg SR (white)</td>
<td>Start at 20 mg in the morning and increase by 20 mg each week until good control is achieved. May need second dose or regular methylphenidate dose in the afternoon. Maximum Recommended Daily Dose: 60 mg</td>
<td>4–8 hours</td>
</tr>
<tr>
<td></td>
<td>• Ritalin LA Capsule (can be sprinkled): 20, 30, and 40 mg</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*These are estimates, as duration may vary with individual child.

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### Stimulant Medications Sustained Release, continued

<table>
<thead>
<tr>
<th>Active Ingredient</th>
<th>Drug Name</th>
<th>Dosing</th>
<th>Duration of Behavioral Effects</th>
</tr>
</thead>
</table>
| Methylphenidate (cont.) | • Metadate ER Tablet: 10 and 20 mg extended release  
• Methylin ER Tablet: 10 and 20 mg extended releases | Start at 10 mg each morning and increase by 10 mg each week until good control is achieved. May need second dose or regular methylphenidate dose in the afternoon. Maximum Recommended Daily Dose: 60 mg | 4–8 hours |
| | • Metadate CD Capsule: 10, 20, and 30 mg extended release (can be sprinkled): | Start at 10 mg each morning and increase by 10 mg each week until good control is achieved Maximum Recommended Daily Dose: 60 mg | 4–8 hours |

### Contraindications and Side Effects

<table>
<thead>
<tr>
<th>Active Ingredient</th>
<th>Contraindications (Stimulants can be used in children with epilepsy.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed salts of amphetamine</td>
<td>MAO Inhibitors within 14 days Glaucoma, Cardiovascular disease, Hyperthyroidism Moderate to severe hypertension</td>
</tr>
<tr>
<td>Dextroamphetamine</td>
<td>MAO Inhibitors within 14 days Glaucoma</td>
</tr>
<tr>
<td>Methylphenidate</td>
<td>MAO Inhibitors within 14 days Glaucoma Preexisting severe gastrointestinal narrowing Caution should be used when prescribing concomitantly with anticoagulants, anticonvulsants, phenylbutazone, and tricyclic antidepressants</td>
</tr>
</tbody>
</table>

**Common Side Effects:** • Decreased appetite • Sleep problems • Transient headache • Transient stomachache • Behavioral rebound

**Infrequent Side Effects:** • Weight loss • Increased heart rate, blood pressure • Dizziness • Growth suppression • Hallucinations/mania • Exacerbation of tics and Tourette syndrome (rare)

**Possible Strategies for Common Side Effects:** (If one stimulant is not working or produces too many adverse side effects, try another stimulant before using a different class of medications.) Decreased Appetite Behavioral Rebound Irritability/Dysphoria • Dose after meals • Try sustained-release stimulant • Decrease dose • Frequent snacks medication • Try another stimulant medication • Drug holidays • Add reduced dose in late afternoon • Consider coexisting conditions, especially depression Sleep Problems Exacerbation of Tics (rare) Psychosis/Euphoria/Mania/Severe • Bedtime routine • Observe Depression • Reduce or eliminate afternoon dose • Reduce dose • Stop treatment with stimulants • Move dosing regimen to earlier time • Try another stimulant or class of • Referral to mental health specialist • Restrict or eliminate caffeine medications

### Non Stimulant Medications

<table>
<thead>
<tr>
<th>Active Ingredient</th>
<th>Drug Name</th>
<th>Dosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atomoxetine HCL</td>
<td>Strattera Capsule: 10mg, 18mg, 25mg, 40 mg, 60mg</td>
<td>Start as a single daily dose, based on weight, 0.5mg/kg/day for the first week then increase up to a max 1.4 mg/kg/day all given in 1 daily dose.</td>
</tr>
</tbody>
</table>

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Does My Child Have ADHD?

Many parents worry about this question. The answer comes from children, families, teachers, and doctors working together as a team. Watching your child's behavior at home and in the community is very important to help answer this question. Your doctor will ask you to fill out rating scales about your child. Watching your child's behavior and talking with other adults in the child's life will be important for filling out the forms.

Here are a few tips about what you can do to help answer the question:

Watch your child closely during activities where he or she should pay attention.

- Doing homework
- Doing chores
- During storytelling or reading

Watch your child when you expect him or her to sit for a while or think before acting.

- Sitting through a family meal
- During a religious service
- Crossing the street
- Being frustrated
- With brothers or sisters
- While you are on the phone

Pay attention to how the environment affects your child's behavior. Make changes at home to improve your child's behavior.

- Ensure that your child understands what is expected. Speak slowly to your child. Have your child repeat the instructions.
- Turn off the TV or computer games during meals and homework. Also, close the curtains if it will help your child pay attention to what he or she needs to be doing.
- Provide structure to home life, such as regular mealtimes and bedtime. Write down the schedule and put it where the entire family can see it. Stick to the schedule.
- Provide your child with planned breaks during long assignments.
- Give rewards for paying attention and sitting, not just for getting things right and finishing. Some rewards might be: dessert for sitting through a meal, outdoor play for finishing homework, and praise for talking through problems.
- Try to find out what things set off problem behaviors. See if you can eliminate the triggers.

If your child spends time in 2 households, compare observations.

- Consult your child's other parent about behavior in that home. Cooperation between parents in this area really helps the child.
- If the child behaves differently, consider differences in the environment that may explain the difference in behavior. Differences are common and not a mark of good or bad parenting.

Talk to your child's teacher.

- Learn about your child's behavior at school. Talk about how your child does during academic lessons and also during play with other children.
- Compare your child's behavior in subjects he or she likes and those in which he or she has trouble with the work.
- Determine how the environment at school affects your child's behavior. When does your child perform well? What events trigger problem behaviors?
- Consider with the teacher whether your child's learning abilities should be evaluated at school. If he or she has poor grades in all subjects or in just a few subjects or requires extra time and effort to learn material, then a learning evaluation may be valuable.

Gather impressions from other adult caregivers who know your child well.

- Scout leaders or religious instructors who see your child during structured activities and during play with other children
- Relatives or neighbors who spend time with your child
- Determine how other environments affect your child's behavior. When does your child perform well? What events trigger problem behaviors?

Make an appointment to see your child's doctor.

- Let the receptionist know you are concerned that your child might have ADHD.
- If possible, arrange a visit when both parents can attend.

Adapted from materials by Heidi Feldman, MD, PhD

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So you think your child may have ADHD, attention-deficit/hyperactivity disorder? Or your child’s teacher thinks your child may have ADHD? There are steps that need to be taken to make a diagnosis of ADHD. Some children may have a learning disability, some children may have difficulty with their hearing or vision, and some children may actually have ADHD. The answer comes from the parents, other family members, doctors, and other professionals working as a team. Here are the steps that the team needs to take to evaluate your child.

The steps in an evaluation are as follows:

1. **Parents make careful observations of the child’s behavior at home.**
2. **Teacher(s) makes careful observations of the child at school.**
3. **Parents and the child’s teacher(s) have a meeting about concerns.**
4. **Parents make an appointment with the child’s doctor. Parents give the doctor the name and phone number of the teacher(s) and school.**
5. **The doctor obtains a history, completes a physical examination (if not done recently), screens the child’s hearing and vision, and interviews the child.**
6. **Parents are given a packet of information about ADHD, including parent and teacher behavior questionnaires, to be filled out before the next visit.**
7. **The teacher(s) returns the questionnaire by mail or fax.**
8. **At a second doctor visit, the doctor reviews the results of the parent and teacher questionnaires and determines if any other testing is required to make a diagnosis of ADHD or other condition.**
9. **The doctor makes a diagnosis and reviews a plan for improvement with the parents.**
10. **The child will need to revisit the doctor until the plan is in place and the child begins to show improvement, and then regularly for monitoring. Parents and teachers may be asked to provide behavior ratings at many times in this process.**

Adapted from materials by Heidi Feldman, MD, PhD

**ADHD Evaluation Timeline**

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General Tips
1. Rules should be clear and brief. Your child should know exactly what you expect from him or her.
2. Give your child chores. This will give him or her a sense of responsibility and boost self-esteem.
3. Short lists of tasks are excellent to help a child remember.
4. Routines are extremely important for children with ADHD.
   Set up regular times for meals, homework, TV, getting up, and going to bed. Follow through on the schedule!
5. Identify what your child is good at doing (like art, math, computer skills) and build on it.
6. Tell your child that you love and support him or her unconditionally.
7. Catch your child being good and give immediate positive feedback.

Common Daily Problems
It is very hard to get my child ready for school in the morning.
- Create a consistent and predictable schedule for rising and getting ready in the morning.
- Set up a routine so that your child can predict the order of events. Put this routine in writing or in pictures on a poster for your child. Schedule example:
  - Alarm goes off ➔ Brush teeth ➔ Wash face ➔ Get dressed ➔ Eat breakfast ➔ Take medication ➔ Get on school bus
- Reward and praise your child! This will motivate your child to succeed. Even if your child does not succeed in all parts of the “morning routine,” use praise to reward your child when he or she is successful. Progress is often made in a series of small steps!
- If your child is on medication, try waking your child up 30 to 45 minutes before the usual wake time and give him or her the medication immediately. Then allow your child to “rest” in bed for the next 30 minutes. This rest period will allow the medication to begin working and your child will be better able to participate in the morning routine.

My child is very irritable in the late afternoon/early evening.
(Common side effect of stimulant medications)
- The late afternoon and evening is often a very stressful time for all children in all families because parents and children have had to “hold it all together” at work and at school.
- If your child is on medication, your child may also be experiencing “rebound” — the time when your child’s medication is wearing off and ADHD symptoms may reappear.
- Adjust your child’s dosing schedule so that the medication is not wearing off during a time of “high demand” (for example, when homework or chores are usually being done).
- Create a period of “downtime” when your child can do calm activities like listen to music, take a bath, read, etc.
- Alternatively, let your child “blow off extra energy and tension” by doing some physical exercise.
- Talk to you child’s doctor about giving your child a smaller dose of medication in the late afternoon. This is called a “stepped down” dose and helps a child transition off of medication in the evening.

My child is losing weight or not eating enough.
(Common side effects of stimulant medication use)
- Encourage breakfast with calorie-dense foods.
- Give the morning dose of medication after your child has already eaten breakfast. Afternoon doses should also be given after lunch.
- Provide your child with nutritious after-school and bedtime snacks that are high in protein and in complex carbohydrates. Examples: Nutrition/protein bars, shakes/drinks made with protein powder, liquid meals.
- Get eating started with any highly preferred food before giving other foods.
- Consider shifting dinner to a time later in the evening when your child’s medication has worn off. Alternatively, allow your child to “graze” in the evening on healthy snacks, as he or she may be hungriest right before bed.
- Follow your child’s height and weight with careful measurements at your child’s doctor’s office and talk to your child’s doctor.

Homework Tips
- Establish a routine and schedule for homework (a specific time and place.) Don’t allow your child to wait until the evening to get started.
- Limit distractions in the home during homework hours (reducing unnecessary noise, activity, and phone calls, and turning off the TV).
- Praise and compliment your child when he or she puts forth good effort and completes tasks. In a supportive, noncritical manner, it is appropriate and helpful to assist in pointing out and making some corrections of errors on the homework.
- It is not your responsibility to correct all of your child’s errors on homework or make him or her complete and turn in a perfect paper.
- Remind your child to do homework and offer incentives: “When you finish your homework, you can watch TV or play a game.”
- If your child struggles with reading, help by reading the material together or reading it to your son or daughter.
- Work a certain amount of time and then stop working on homework.

“Common Daily Problems” adapted from material developed by Laurel K. Leslie, M.D, San Diego ADHD Project.

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Many parents find it very difficult to help their own child with schoolwork. Find someone who can. Consider hiring a tutor! Often a junior or senior high school student is ideal, depending on the need and age of your child.

**Discipline**
- Be firm. Set rules and keep to them.
- Make sure your child understands the rules, so he or she does not feel uninformed.
- Use positive reinforcement. Praise and reward your child for good behavior.
- Change or rotate rewards frequently to maintain a high interest level.
- Punish behavior, not the child. If your child misbehaves, try alternatives like allowing natural consequences, withdrawing yourself from the conflict, or giving your child a choice.

**Taking Care of Yourself**
- Come to terms with your child’s challenges and strengths.
- Seek support from family and friends or professional help such as counseling or support groups.
- Help other family members recognize and understand ADHD.

"Common Daily Problems" adapted from material developed by Laurel K. Leslie, M.D., San Diego ADHD Project.
Many children with ADHD have difficulty sleeping at night, whether or not they are on medication. This is partially related to the ADHD; parents often describe their children as being “on the go” and collapsing late at night. It may also be due to the fact that stimulant medication has worn off, making it more difficult for them to manage their behavior. Lastly, some children have difficulty falling asleep because the stimulants affect them the same way caffeine affects adults.

Here are a few tips:

- **Establish consistent waking times.**
  - Bedtimes and waking times should be the same 7 days a week.
  - It is easier to enforce a waking time than a bedtime.

- **Avoid drinks with caffeine.**
  - Caffeine is present in a wide range of beverages, such as tea, soda, cocoa, and coffee. Drinking these beverages past the afternoon may make it more difficult for your child to settle down to sleep.

- **Establish daytime routines.**
  - Regular mealtimes and activity times, including playtime with parents, also help set sleep times.

- **Chart your child’s progress.**
  - Praise your child for successful quiet nights.
  - Consider marking successful nights on a star chart and providing rewards at the end of the week.

- **Waking up at night is a habit.**
  - Social contact with parents, feeding, and availability of interesting toys encourage the child to be up late, so set limits on attention-getting behaviors at night.

- **Consider medical problems.**
  - Allergy, asthma, or conditions that cause pain can disrupt sleep. If your child snores loudly and/or pauses in breathing, talk to your doctor.

- **Try medications to help your child sleep only under the care of your child’s doctor.**
  - Medications need to be used very carefully in young children. Many medications can have complications and make sleep worse.
  - Some children with ADHD may actually be helped by a small dose of a stimulant medication at bedtime. Paradoxically, this dose may help a child to get organized for sleep.
  - Some children may ultimately need other bedtime medications—at least for a little while—to help improve sleep. Talk with your doctor before starting any over-the-counter or prescription medications.

Adapted from material developed by Laurel K. Leslie, MD, San Diego ADHD Project, and from material developed by Henry L. Shapiro, MD, FAAP, for the Pediatric Development and Behavior Web site (www.dbpeds.org).

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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There are 2 main laws protecting students with disabilities—including those with ADHD: 1) the Individuals with Disabilities Education Act of 1997 (IDEA) and 2) Section 504 of the Rehabilitation Act of 1973. IDEA is special education law. Section 504 is a civil rights statute. Both laws guarantee to qualified students a free and appropriate public education (FAPE) and instruction in the least restrictive environment (LRE), which means with their peers who are not disabled and to the maximum extent appropriate to their needs.

Because there are different criteria for eligibility, services/supports available, and procedures and safeguards for implementing the laws, it is important for parents, educators, clinicians, and advocates to be well aware of the variations between IDEA and Section 504 and fully informed about the respective advantages and disadvantages.

Additional Resources
   Learning Disabilities Association of America, 1992. Contact the publisher at 4156 Library Rd, Pittsburgh, PA 15243 or 888/300-6710.
2. Better IEPs: How to Develop Legally Correct and Educationally Useful Programs
3. The Complete IEP Guide: How to Advocate for Your Special Ed Child
4. Negotiating the Special Education Maze: A Guide for Parents and Teachers
   Winifred Anderson, Stephen Chitwood, and Deidre Hayden; 3rd edition; 1997. Contact the publisher, Woodbine House, at 6510 Bells Mill Rd, Bethesda, MD 20817 or 800/843-7323.
5. Children and Adults With Attention-Deficit/Hyperactivity Disorder
   http://www.chadd.org
6. Education Resources Information Center
   http://ericir.syr.edu
7. Internet Resource for Special Children
   http://www.irsc.org
8. San Diego ADHD Web Page
   http://www.sandiegoadhd.org
9. National Information Center for Children and Youth with Disabilities
   http://www.nichcy.org
10. Parent Advocacy Coalition for Educational Rights Center
    http://www.pacer.org

Glossary of Acronyms

ADHD
Attention-deficit/hyperactivity disorder
BIP
Behavioral Intervention Plan
ED
Emotional disturbance
FAPE
Free and appropriate public education
FBA
Functional Behavioral Assessment
IDEA
Individuals with Disabilities Education Act
IEP
Individualized Education Program
IST
Instructional Support Team
LRE
Least restrictive environment
MDR
Manifestation Determination Review
MDT
Multidisciplinary Team
OHI
Other health impaired
SLD
Specific learning disability
SST
Student Study Team
Who Is Eligible?
IDEA strongly emphasizes the provision of special education and related services that enable students to access and progress in the general education program. Sometimes students with ADHD qualify for special education and related services under the disability categories of “specific learning disability” (SLD) or “emotional disturbance” (ED). For example, a child who has ADHD who also has coexisting learning disabilities may be eligible under the SLD category. Students with ADHD most commonly are eligible for special education and related services under the IDEA category of “other health impaired” (OHI). Eligibility criteria under this category require that the child has a chronic or acute health problem (eg, ADHD) causing limited alertness to the educational environment (due to heightened alertness to environmental stimuli) that results in an adverse effect on the child’s educational performance to the degree that special education is needed.

Note: The adverse effect on educational performance is not limited to academics, but can include impairments in other aspects of school functioning, such as behavior, as well.

How Does a Parent Access Services Under IDEA?
- Parents or school personnel may refer a child by requesting an evaluation to determine eligibility for special education and related services. It is best to put this request in writing.
- Within a limited time frame, the school’s multidisciplinary evaluation team, addressing all areas of the child’s difficulties, develops an assessment plan.
- After parents or guardians consent to the assessment plan, the child receives a comprehensive evaluation by the multidisciplinary team of school professionals.
- After the evaluation, an Individualized Education Program (IEP) meeting is scheduled with the team, including parents, teacher(s), special education providers, the school psychologist and/or educational evaluator, a school system representative, and the student (as appropriate).

IDEA

Based on the results of the evaluation, as well as other input provided by parents and/or other team members, the team decides whether the child meets eligibility criteria for special education under one of the categories defined by IDEA.
- An IEP is developed and written for qualifying students through a collaborative team effort. It is tailored and designed to address the educational needs of the student.
- The IEP goes into effect once the parents sign it and agree to the plan.
- The IEP must address the following:
  - Present levels of educational performance, including how the child’s disability affects his or her involvement and progress in the general curriculum
  - Delineation of all special education and related services, modifications (if any), and supports to be provided to the child or on behalf of the child
  - Annual goals and measurable, short-term objectives/benchmarks
  - The extent (if any) to which the child will not participate with children in the regular class and other school activities
  - Modifications (if any) in the administration of statewide and district-wide tests the child will need to participate in those assessments
  - Dates and places specifying when, where, and how often services will be provided, and by whom

What Happens After the IEP Is Written?
1. Services are provided. These include all programs, supplemental aids, program modifications, and accommodations that are spelled out in the IEP.
2. Progress is measured and reported to parents. Parents are informed of progress toward IEP goals during the year, and an annual IEP review meeting is required.
3. Students are reevaluated every 3 years (triennial evaluation) or sooner if deemed necessary by the team or on parent/teacher request.

Educational Rights for Children With ADHD

Section 504

Who Is Eligible?
Students with ADHD also may be protected under Section 504 of the Rehabilitation Act of 1973 (even if they do not meet eligibility criteria under IDEA for special education). To determine eligibility under Section 504 (ie, the impact of the disability on learning), the school is required to do an assessment. This typically is a much less extensive evaluation than that conducted for the IEP process.

Section 504 is a federal civil rights statute that:

- Protects the rights of people with disabilities from discrimination by any agencies receiving federal funding (including all public schools)
- Applies to students with a record of (or who are regarded as having) a physical or mental impairment that substantially limits one or more major life function (which includes learning)
- Is intended to provide students with disabilities equal access to education and commensurate opportunities to learn as their peers who are not disabled

How Does a Parent Access Services Under Section 504?

- Parents or school personnel may refer a child by requesting an evaluation to determine eligibility for special education and related services. It is best to put this request in writing.
- If the school determines that the child’s ADHD does significantly limit his or her learning, the child would be eligible for a 504 plan designating:
  - Reasonable accommodations in the educational program
  - Related aids and services, if deemed necessary (eg, counseling, assistive technology)

What Happens After the 504 Plan Is Written?
The implementation of a 504 plan typically falls under the responsibility of general education, not special education. A few sample classroom accommodations may include:

- Tailoring homework assignments
- Extended time for testing
- Preferential seating
- Supplementing verbal instructions with visual instructions
- Organizational assistance
- Using behavioral management techniques
- Modifying test delivery

What Do Section 504 and IDEA Have in Common?

Both:

- Require school districts to provide free and appropriate public education (FAPE) in the least restrictive environment (LRE)
- Provide a variety of supports (adaptations/accommodations/modifications) to enable the student to participate and learn in the general education program
- Provide an opportunity for the student to participate in extracurricular and nonacademic activities
- Require nondiscriminatory evaluation by the school district
- Include due process procedures if a family is dissatisfied with a school’s decision

Which One Is Right for My Child—a 504 Plan or an IEP?
This is a decision that the team (parents and school personnel) must make considering eligibility criteria and the specific needs of the individual student. For students with ADHD who have more significant school difficulties:

IDEA usually is preferable because:

- It provides for a more extensive evaluation.
- Specific goals and short-term objectives are a key component of the plan and regularly monitored for progress.
- There is a much wider range of program options, services, and supports available.
- It provides funding for programs/services (Section 504 is non-funded).
- It provides more protections (procedural safeguards, monitoring, regulations) with regard to evaluation, frequency of review, parent participation, disciplinary actions, and other factors.

A 504 plan would be preferable for:

- Students who have milder impairments and don’t need special education. A 504 plan is a faster, easier procedure for obtaining accommodations and supports.
- Students whose educational needs can be addressed through adjustments, modifications, and accommodations in the general curriculum/classroom.


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Sample Letter #1:
Request for Assessment for Educational Services Under Section 504

(Date)

School Site Principal's Name
School Name
Address

RE: (Student’s Name and Grade)

Dear (Principal's Name)*:

I am the parent of (Student’s Name), who is in Mr/Ms (Teacher’s Name)’s class. (Student’s Name) has been experiencing school problems for some time now. We have been working with the teacher(s) to modify (his/her) regular education program but (we have not seen any improvement or the problems have been getting worse). Therefore, I wish to request an assessment of my child for appropriate educational services and interventions according to the provisions of Section 504 of the Rehabilitation Act.

I look forward to working with you as soon as possible to develop an assessment plan to begin the evaluation process. I request copies of the assessment results 1 week prior to the meeting.

Thank you for your assistance. I can be reached by phone at (Area Code and Phone Number). The best time to reach me is (times/days).

Sincerely,

(Sign Your Name)
(Print Your Name)
(Address)
(Telephone Number)

Adapted from San Diego Learning Disabilities Association.
http://ldasandiego.org/

Note: Remember to keep a copy for your files.
*If the principal does not respond, contact the district 504 coordinator. It is recommended that you either write a letter or document your phone conversation. If you do not get a response, you have the right to file a compliance complaint.
Sample Letter #2:  
Request for Assessment for Special Education

(Date)

School Site Principal's Name: 
School Name
Address

RE: (Student’s Name and Grade)

Dear (Principal's Name)*:

I am the parent of (Student's name) who is in Mr/Ms (Teacher's Name)'s class. (Student's Name) has been experiencing school problems for some time now. These problems include:______________________________________________
______________________________________________________________________________________________

We have been working with the teacher(s) to modify (his/her) regular education program but (we have not seen any improvement or the problems have been getting worse). Therefore, I wish to request an assessment of my child for possible special education services according to the provisions of IDEA.

I look forward to working with you within the next 15 days to develop an assessment to begin the evaluation process. Please ensure that I receive copies of the assessment results 1 week prior to the IEP meeting. Thank you for your assistance. I can be reached by phone at (Area Code and Phone Number). The best time to reach me is (times/days).

Sincerely,

Sign your name
Print your name
Street Address
City, State, ZIP

Doctor's Signature
License Number
Practice Address
City, State, ZIP

Adapted from San Diego Learning Disabilities Association.  
http://ldasandiego.org/
Homework Tips for Parents

- Establish a routine and schedule for homework (a specific time and place) and adhere to the schedule as closely as possible. Don't allow your child to wait until the evening to get started.
- Limit distractions in the home during homework hours (e.g., reduce unnecessary noise, activity, and phone calls; turn off the TV).
- Assist your child in dividing assignments into smaller parts or segments that are more manageable and less overwhelming.
- Assist your child in getting started on assignments (e.g., read the directions together, do the first items together, observe as your child does the next problem/item on his or her own). Then get up and leave.
- Monitor and give feedback without doing all the work together. You want your child to attempt as much as possible independently.
- Praise and compliment your child when he or she puts forth good effort and completes tasks. In a supportive, noncritical manner it is appropriate and helpful to assist in pointing out and making some corrections of errors on the homework.
- It is not your responsibility to correct all of your child's errors on homework or make him or her complete and turn in a perfect paper.
- Remind your child to do homework and offer incentives: "When you finish your homework, you can..."
- A contract for a larger incentive/reinforcer may be worked out as part of a plan to motivate your child to persist and follow through with homework. ("If you have no missing or late homework assignments this next week, you will earn... ").
- Let the teacher know your child's frustration and tolerance level in the evening. The teacher needs to be aware of the amount of time it takes your child to complete tasks and what efforts you are making to help at home.
- Help your child study for tests. Study together. Quiz your child in a variety of formats.
- If your child struggles with reading, help by reading the material together or reading it to your son or daughter.
- Work a certain amount of time and then stop working on homework. Don't force your child to spend an excessive and inappropriate amount of time on homework. If you feel your child worked enough for one night, write a note to the teacher attached to the homework.
- It is very common for students with ADHD to fail to turn in their finished work. It is very frustrating to know your child struggled to do the work, but then never gets credit for having done it. Papers seem to mysteriously vanish off the face of the earth! Supervise to make sure that completed work leaves the home and is in the notebook/backpack. You may want to arrange with the teacher a system for collecting the work immediately on arrival at school.
- Many parents find it very difficult to help their own child with schoolwork. Find someone who can. Consider hiring a tutor! Often a junior or senior high school student is ideal, depending on the needs and age of your child.
- Make sure your child has the phone number of a study buddy— at least one responsible classmate to call for clarification of homework assignments.
- Parents, the biggest struggle is keeping on top of those dreaded long-range homework assignments (e.g., reports, projects). This is something you will need to be vigilant about. Ask for a copy of the project requirements. Post the list at home and go over it together with your child. Write the due date on a master calendar. Then plan how to break down the project into manageable parts, scheduling steps along the way. Get started AT ONCE with going to the library, gathering resources, beginning the reading, and so forth.

Why Is My Child Having Trouble in School?
It is very common for children with ADHD to have difficulties in school. These problems can occur for several reasons:

- Symptoms of ADHD like distractibility and hyperactivity make it hard for children with ADHD to pay attention or stay focused on their work, even though they may be capable learners and bright enough to understand the material.
- Many children with ADHD also have trouble organizing themselves, breaking an assignment down into smaller steps, and staying on a schedule.
- Some children with ADHD have difficulty with self-control and get into trouble with peers and/or teachers.
- Many children with ADHD also have a learning disability. Schools usually define a learning disability as a discrepancy between a child's IQ score and his or her performance on achievement tests. A child with a learning disability has difficulty understanding information he or she sees or hears OR trouble putting together information from different parts of the brain.
- Children with ADHD often can learn material but it may take longer and require more repetition.
- Children with ADHD often show inconsistency in their work because of their ADHD; one day they may know information and the next day they cannot seem to remember it.

Typical School Performance Difficulties Associated With ADHD

- Poor organization and study skills
- Weaknesses in written language/writing skills
- Minimal/inconsistent production and output (both in-class assignments and homework)
- Behavior that interferes with learning and impacts on interpersonal relationships
- Immature social skills

What Can I Personally Do to Help?
There are many different ways that a parent’s participation can make a difference in a child's school experience, including:

- Spending time in the classroom, if your work schedule allows, and observing your child's behavior.
- Talking with your child's teacher to identify where your child is having the most problems.
- Working with your child's teacher to make a plan for how you will address these problems and what strategies at school and home will help your child be successful at learning and completing work.
- Acknowledging the extra efforts your child's teacher may have to make to help your child.
- Reading all you can about ADHD and sharing it with your child's teacher and other school officials.
- Becoming an expert on ADHD and your child.
- Finding out about tutoring options through your child's school or local community groups. Children with ADHD may take longer to learn material compared with other children even though they are just as smart. Tutoring may help your child master new materials.
- Making sure your child actually has mastered new material presented so that he or she does not get behind academically.
- Acknowledging how much harder it is for your child to get organized, stay on task, complete assignments, and learn material compared with other children. Help your child to get organized, break tasks down into smaller pieces, and expend his or her excess physical energy in ways that are “okay” at home and in the classroom.
- Praising your child and rewarding him or her for a job well done immediately after completing tasks or homework.
- Joining a support group for parents of children with ADHD or learning disabilities. Other parents may help you with ideas to help your child.

Another good way to get help from your school is to determine if your school has a regular education process that helps teachers with students who are having learning or behavioral problems that the teacher has been unsuccessful in solving. The process differs in various school districts and even among different schools in the same district. Some of the names this process may go by include Student Study Team (SST), Instructional Support Team (IST), Pupil Assistance Team (PAT), Student Intervention Team (SIT), or Teacher Assistance Team (TAT).

Parents are encouraged to request a meeting on their child to discuss concerns and create a plan of action to address their child's needs. In addition to the child's teacher, members of the team may include the child, the parents, a mentor teacher or other teachers, the principal, the school nurse, the resource specialist, a speech and language specialist, or a counselor or psychologist. The team members meet to discuss the child’s strengths and weaknesses, the child’s progress in his or her current placement, and the kinds of problems the child is having. The team members “brainstorm” to develop a plan of action that documents the kinds of interventions that will help the child, the timeline for the changes to take place, and the school staff responsible for the implementation of the team's recommendations.

The team should also come up with a plan to monitor the child’s progress. A follow-up meeting should be scheduled within a reasonable time frame (usually 4 to 6 weeks) to determine whether the team's interventions are actually helping the child in the areas of difficulty.
ADHD Coding Fact Sheet for Primary Care Clinicians


Initial assessment usually involves time determining the differential diagnosis, a diagnostic plan, and potential treatment options. Therefore, most clinicians will report either an office/outpatient evaluation and management (E/M) code using time as the key factor* or a consultation code for the initial assessment.

Office or Other Outpatient E/M Codes

99201/99202/99203/99204/99205 Use for new† patients only; require 3 of 3 key components or greater than 50 percent of the visit spent in counseling or coordinating care.

99212/99213/99214/99215 Use for established patients; require 2 of 3 key components or greater than 50 percent of the visit spent in counseling or coordinating care.

Office or Other Outpatient Consultation Codes

99241/99242/99243/99244/99245 Use for new or established patients; appropriate to report if another physician or other appropriate source (ie, school nurse, psychologist) requests an opinion regarding a child potentially having ADHD. Require 3 of 3 key components or greater than 50 percent of the visit spent in counseling or coordinating care.

NOTE: Use of these codes requires the following:

• Written or verbal request for consultation is documented in the patient chart.
• Consultant's opinion as well as any services ordered or performed are documented in the patient chart.
• Consultant's opinion and any services that are performed are prepared in a written report, which is sent to the requesting physician or other appropriate source.

Prolonged Physician Services Codes

99354/99355 Use for outpatient face-to-face prolonged services.

99358/99359 Use for non-face-to-face prolonged services in any setting.

• Used when a physician provides prolonged services beyond the usual service (ie, beyond the typical time).
• An alternate to using time as the key factor with the office/outpatient E/M codes (99201–99215).
• Time spent does not have to be continuous.
• Codes are “add-on” codes, meaning they are reported separately in addition to the appropriate code for the service provided (eg, office or other outpatient E/M codes, 99201–99215).

• If the physician spends at least 30 and no more than 74 minutes more than the typical time associated with the reported E/M code, he or she can report 99354 (for face-to-face contact) or 99358 (for non-face-to-face contact). Codes 99355 (each additional 30 minutes of face-to-face prolonged service) and 99359 (each additional 30 minutes of non-face-to-face prolonged service) are used to report each additional 30 minutes of service beyond the first 74 minutes.
• Prolonged service of less than 15 minutes beyond the first hour or less then 15 minutes beyond the final 30 minutes is not reported separately.

*Time can be used as the key factor in determining a level of service when counseling and/or coordinating care constitute more than 50% of the encounter.
†A new patient is defined as one who has not received any professional services from a physician, or another physician of the same specialty who belongs to the same group practice, within the past 3 years (Principles of CPT Coding [second edition], American Medical Association, 2001).

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While every effort has been made to ensure the accuracy of this information, it is not guaranteed that this document is accurate, complete, or without error.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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ADHD Coding Fact Sheet for Primary Care Clinicians

Case Management Services Codes

99361/99362 Use to report a medical conference among the physician and an interdisciplinary team of health professionals to coordinate activities of patient care (patient not present).

99371/99372/99373 Use to report telephone calls made by the physician to patient or parent, for consultation or medical management, or for coordinating medical management with other health care professionals.

Central Nervous System Assessments/Tests Codes

96100 Use to report psychological testing, per hour; includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities (e.g., WAIS-R, Rorschach test, MMPI).

96110 Use to report limited developmental testing with interpretation and report (e.g., Developmental Screening Test II, Early Language Milestone Screen).

96115 Use to report neurobehavioral status examination with interpretation and report, per hour (e.g., Conners Continuous Performance Test, Hawthorne Test).

Other Psychiatric Services or Procedures Codes

90862 Use to report pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (e.g., Ritalin check).

90887 Use to report interpretation or explanation of results of psychiatric, other medical examinations or procedures, or other accumulated data to patient’s family/guardian(s), or advising them how to assist patient.

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and Diagnostic and Statistical Manual for Primary Care (DSM-PC) Codes

- Before ADHD is diagnosed, do not use “rule out ADHD” as the diagnosis. Use as many diagnosis codes as apply to document the patient’s complexity and report the patient’s symptoms and/or adverse environmental circumstances.

- Once a definitive ADHD diagnosis is established, report the appropriate definitive diagnosis code(s) as the primary code, plus any other symptoms that the patient is exhibiting as secondary diagnoses.

- Counseling diagnosis codes can be used when the patient is present or when counseling the parent/guardian(s) when the patient is not physically present.

ICD-9-CM Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>293.84</td>
<td>Organic anxiety syndrome</td>
</tr>
<tr>
<td>300.00</td>
<td>Anxiety state, unspecified</td>
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<tr>
<td>300.01</td>
<td>Panic disorder</td>
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<tr>
<td>300.02</td>
<td>Generalized anxiety disorder</td>
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<tr>
<td>300.20</td>
<td>Phobia, unspecified</td>
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<tr>
<td>300.23</td>
<td>Social phobia</td>
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<tr>
<td>300.29</td>
<td>Other isolated or simple phobia</td>
</tr>
<tr>
<td>300.4</td>
<td>Neurotic depression</td>
</tr>
<tr>
<td>307.0</td>
<td>Stammering and stuttering</td>
</tr>
<tr>
<td>307.9</td>
<td>Other and unspecified special symptoms or syndromes, not elsewhere classified (NEC)</td>
</tr>
<tr>
<td>309.21</td>
<td>Separation anxiety disorder</td>
</tr>
<tr>
<td>309.3</td>
<td>Adjustment reaction; with predominant disturbance of conduct</td>
</tr>
<tr>
<td>312.00</td>
<td>Undersocialized conduct disorder, aggressive type; unspecified</td>
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<tr>
<td>312.30</td>
<td>Impulse control disorder, unspecified</td>
</tr>
<tr>
<td>312.81</td>
<td>Conduct disorder, childhood onset type</td>
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<tr>
<td>312.82</td>
<td>Conduct disorder, adolescent onset type</td>
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<tr>
<td>312.9</td>
<td>Unspecified disturbance of conduct</td>
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<tr>
<td>313.81</td>
<td>Oppositional disorder</td>
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<tr>
<td>313.83</td>
<td>Academic underachievement disorder</td>
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<tr>
<td>314.00</td>
<td>Attention-deficit disorder, without mention of hyperactivity</td>
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<tr>
<td>314.01</td>
<td>Attention-deficit disorder, with mention of hyperactivity</td>
</tr>
<tr>
<td>314.1</td>
<td>Hyperkinesia with developmental delay</td>
</tr>
<tr>
<td>314.2</td>
<td>Hyperkinetic conduct disorder</td>
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<tr>
<td>314.8</td>
<td>Other specified manifestations of hyperkinetic syndrome</td>
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<tr>
<td>314.9</td>
<td>Unspecified hyperkinetic syndrome</td>
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<tr>
<td>315.00</td>
<td>Reading disorder, unspecified</td>
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<td>315.01</td>
<td>Alexia</td>
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<tr>
<td>315.02</td>
<td>Developmental dyslexia</td>
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<td>315.09</td>
<td>Specific reading disorder; other</td>
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<tr>
<td>315.1</td>
<td>Specific arithmetical disorder</td>
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<td>315.2</td>
<td>Other specific learning difficulties</td>
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<td>315.31</td>
<td>Developmental language disorder</td>
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<tr>
<td>315.32</td>
<td>Receptive language disorder (mixed)</td>
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<td>315.39</td>
<td>Developmental speech or language disorder; other</td>
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<tr>
<td>315.4</td>
<td>Coordination disorder</td>
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<td>315.5</td>
<td>Mixed speech or language disorder</td>
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<tr>
<td>315.8</td>
<td>Other specified delay in development</td>
</tr>
<tr>
<td>315.9</td>
<td>Unspecified delay in development</td>
</tr>
<tr>
<td>781.3</td>
<td>Lack of coordination</td>
</tr>
</tbody>
</table>

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### ICD-9-CM Codes, continued

**NOTE:** The ICD-9-CM codes below are used to deal with occasions when circumstances other than a disease or injury are recorded as "diagnoses" or "problems." Some carriers may request supporting documentation for the reporting of V codes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V40.0</td>
<td>Problems with learning</td>
</tr>
<tr>
<td>V40.1</td>
<td>Problems with communication (including speech)</td>
</tr>
<tr>
<td>V40.3</td>
<td>Mental and behavioral problems; other behavioral problems</td>
</tr>
<tr>
<td>V40.9</td>
<td>Unspecified mental or behavioral problem</td>
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<tr>
<td>V60.0</td>
<td>Lack of housing</td>
</tr>
<tr>
<td>V60.1</td>
<td>Inadequate housing</td>
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<tr>
<td>V60.2</td>
<td>Inadequate material resources</td>
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<tr>
<td>V60.8</td>
<td>Other specified housing or economic circumstances</td>
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<tr>
<td>V61.20</td>
<td>Counseling for parent-child problem, unspecified</td>
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<tr>
<td>V61.29</td>
<td>Parent-child problems; other</td>
</tr>
<tr>
<td>V61.49</td>
<td>Health problems with family; other</td>
</tr>
<tr>
<td>V61.8</td>
<td>Health problems within family; other specified family circumstances</td>
</tr>
<tr>
<td>V61.9</td>
<td>Health problems within family; unspecified family circumstances</td>
</tr>
<tr>
<td>V62.0</td>
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<tr>
<td>V62.5</td>
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</tr>
<tr>
<td>V62.81</td>
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</tr>
<tr>
<td>V62.82</td>
<td>Bereavement, uncomplicated</td>
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<tr>
<td>V62.89</td>
<td>Other psychological or physical stress, NEC; other</td>
</tr>
<tr>
<td>V62.9</td>
<td>Unspecified psychosocial circumstance</td>
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<tr>
<td>V65.49</td>
<td>Other specified counseling</td>
</tr>
<tr>
<td>V71.02</td>
<td>Observation for suspected mental condition; childhood or adolescent antisocial behavior</td>
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</table>

### DSM-PC Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>300.01</td>
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<tr>
<td>300.02</td>
<td>Generalized anxiety disorder</td>
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<td>300.23</td>
<td>Social phobia</td>
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<td>300.29</td>
<td>Specific phobia</td>
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<tr>
<td>307.0</td>
<td>Stuttering</td>
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<tr>
<td>307.9</td>
<td>Communication disorder, not otherwise specified (NOS)</td>
</tr>
<tr>
<td>308.3</td>
<td>Acute stress disorder</td>
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<td>309.21</td>
<td>Separation anxiety disorder</td>
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<tr>
<td>309.81</td>
<td>Posttraumatic stress disorder</td>
</tr>
<tr>
<td>312.81</td>
<td>Conduct disorder, childhood onset</td>
</tr>
<tr>
<td>312.82</td>
<td>Conduct disorder, adolescent onset</td>
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<td>312.9</td>
<td>Disruptive behavior disorder, NOS</td>
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<tr>
<td>313.81</td>
<td>Oppositional-defiant disorder</td>
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<tr>
<td>314.00</td>
<td>Predominantly Inattentive type</td>
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<tr>
<td>314.01</td>
<td>Predominantly Hyperactive-Impulsive type</td>
</tr>
<tr>
<td>314.01</td>
<td>Combined type</td>
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<tr>
<td>314.9</td>
<td>Attention-deficit/hyperactivity disorder, NOS</td>
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<tr>
<td>315.0</td>
<td>Reading disorder (developmental reading disorder)</td>
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<td>315.1</td>
<td>Mathematics disorder (developmental arithmetic disorder)</td>
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<tr>
<td>315.2</td>
<td>Disorder of written expression (developmental expressive disorder)</td>
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<tr>
<td>315.31</td>
<td>Expressive language disorder</td>
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<td>315.32</td>
<td>Mixed receptive-expressive language disorder</td>
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<tr>
<td>315.39</td>
<td>Phonologic disorder</td>
</tr>
<tr>
<td>315.4</td>
<td>Developmental coordination disorder</td>
</tr>
<tr>
<td>315.9</td>
<td>Learning disorder, NOS</td>
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<tr>
<td>781.3</td>
<td>Developmental coordination problem</td>
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<td>Anxiety problem</td>
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<td>Hyperactive/impulsive behavior problem</td>
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<td>Inattention problem</td>
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<td>Sadness problem</td>
</tr>
<tr>
<td>V62.3</td>
<td>Developmental/cognitive problem</td>
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<td>V62.82</td>
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<td>Aggressive/oppositional variation</td>
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<td>V65.4</td>
<td>Developmental/cognitive variation</td>
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<td>Hyperactive/impulsive variation</td>
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<tr>
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<td>Inattention variation</td>
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<td>V65.49</td>
<td>Learning variation</td>
</tr>
<tr>
<td>V65.49</td>
<td>Negative emotional behavior variation</td>
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<td>V65.49</td>
<td>Sadness variation</td>
</tr>
<tr>
<td>V65.49</td>
<td>Secretive antisocial behaviors variation</td>
</tr>
<tr>
<td>V65.49</td>
<td>Speech and language variation</td>
</tr>
<tr>
<td>V71.02</td>
<td>Aggressive/oppositional problem</td>
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<tr>
<td>V71.02</td>
<td>Negative emotional behavior problem</td>
</tr>
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<td>V71.02</td>
<td>Secretive antisocial behaviors problem</td>
</tr>
</tbody>
</table>
ADHD Encounter Form

Today’s Date: ___________  Child’s Name: ____________________________________________    Age: ________________

Sex:  □ Male  □ Female  BD: ________________  M R# ________________  Parent Name(s): ________________________

CPT Procedure Codes (Circle the codes that apply.)

<table>
<thead>
<tr>
<th>Evaluation and Management (E/M)</th>
<th>New or Established</th>
<th>Office Visits</th>
<th>New Patients</th>
<th>Office Visits</th>
<th>Established Patients</th>
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<tr>
<td>Focused</td>
<td>99241</td>
<td>Focused</td>
<td>99201</td>
<td>Minimal</td>
<td>99211</td>
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<tr>
<td>Expanded</td>
<td>99242</td>
<td>Expanded</td>
<td>99202</td>
<td>Focused</td>
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<tr>
<td>Detailed</td>
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<td>Detailed</td>
<td>99203</td>
<td>Expanded</td>
<td>99213</td>
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<tr>
<td>Moderately complex</td>
<td>99244</td>
<td>Moderately complex</td>
<td>99204</td>
<td>Detailed/Moderately complex</td>
<td>99214</td>
</tr>
<tr>
<td>Highly complex</td>
<td>99245</td>
<td>Highly complex</td>
<td>99205</td>
<td>Highly complex</td>
<td>99215</td>
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</table>

Prolonged Face-to-Face Services (Report in addition to E/M code.)

- Prolonged face-to-face service; first hour
  - 99354

Other Services

<table>
<thead>
<tr>
<th>Psychological testing, per hour 96100</th>
<th>Developmental testing, limited, per hour 96110</th>
<th>Developmental testing, extended, per hour 96111</th>
<th>Neurobehavioral status exam, per hour 96115</th>
<th>Individual psychotherapy (20-30 minutes) 90804</th>
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</thead>
<tbody>
<tr>
<td>Individual psychotherapy (45-50 minutes) 90806</td>
<td>Group psychotherapy 90853</td>
<td>Family psychotherapy 90846 or 90847</td>
<td>Team conference (30 minutes) 99361</td>
<td>Team conference (60 minutes) 99362</td>
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<tr>
<td>Telephone consult 99371, 99372, or 99373</td>
<td>Home visit 99341-50</td>
<td>Group counseling with symptoms 99078</td>
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ICD-9-CM Diagnosis Codes (Circle all codes that apply.)

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<tbody>
<tr>
<td>ADD w/out mention of hyperactivity</td>
<td>314.00</td>
<td>ADD with hyperactivity</td>
<td>314.01</td>
<td>Hyperkinesis w/ developmental delay</td>
<td>314.1</td>
<td>Hyperkinetic conduct disorder</td>
<td>314.2</td>
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<tr>
<td>Other specified manifestations of hyperkinetic syndrome</td>
<td>314.8</td>
<td>Unspecified hyperkinetic syndrome</td>
<td>314.9</td>
<td>Other specified counseling</td>
<td>V65.49</td>
<td>Mental and behavioral problems; other behavioral problems</td>
<td>V40.3</td>
<td></td>
</tr>
</tbody>
</table>

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National Initiative for Children's Healthcare Quality
### Adverse Environmental Circumstances

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Lack of housing</td>
<td>V 60.0</td>
<td>Inadequate</td>
<td>V 60.1</td>
<td>Inadequate material</td>
<td>V 60.2</td>
<td>Other specified housing or economic circumstances</td>
<td>V 60.8</td>
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<tr>
<td>Counseling for parent-child problem, unspecified</td>
<td>V 61.20</td>
<td>Parent-child problems, other</td>
<td>V 61.29</td>
<td>Counseling for marital and partner problems, unspecified</td>
<td>V 61.10</td>
<td>Health problems within family; other</td>
<td>V 61.49</td>
</tr>
<tr>
<td>Health problems within family; other specified family circumstances</td>
<td>V 61.8</td>
<td>Health problems within family; unspecified family circumstances</td>
<td>V 61.9</td>
<td>Other psychosocial circumstances; unemployment</td>
<td>V 62.0</td>
<td>Other psychosocial circumstances; legal circumstances</td>
<td>V 62.5</td>
</tr>
<tr>
<td>Interpersonal problems, not elsewhere classified (NEC)</td>
<td>V 62.81</td>
<td>Bereavement, uncomplicated</td>
<td>V 62.82</td>
<td>Other psychological or physical stress, NEC; other</td>
<td>V 62.89</td>
<td>Unspecified psychosocial circumstances</td>
<td>V 62.9</td>
</tr>
<tr>
<td>Child neglect (nutritional)</td>
<td>995.52</td>
<td>Child sexual abuse</td>
<td>995.53</td>
<td>Child physical abuse</td>
<td>995.54</td>
<td>Perpetrator of child and adult abuse</td>
<td>E967.0-E967.9</td>
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</table>

### Anxiety and Depression

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<tbody>
<tr>
<td>Organic anxiety syndrome</td>
<td>293.84</td>
<td>Major depressive disorder, single episode, unspecified</td>
<td>296.20</td>
<td>Major depressive disorder, single episode, mild</td>
<td>296.21</td>
<td>Major depressive disorder, single episode, moderate</td>
<td>296.22</td>
</tr>
<tr>
<td>Major depressive disorder, single episode, severe, without mention of psychotic behavior</td>
<td>296.23</td>
<td>Major depressive disorder, recurrent episode, unspecified</td>
<td>296.30</td>
<td>Major depressive disorder, recurrent episode, mild</td>
<td>296.31</td>
<td>Major depressive disorder, recurrent episode, moderate</td>
<td>296.32</td>
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<tr>
<td>Major depressive disorder, recurrent episode, severe, without mention of psychotic behavior</td>
<td>296.33</td>
<td>Anxiety state, unspecified</td>
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<td>Panic disorder</td>
<td>300.01</td>
<td>Generalized anxiety disorder</td>
<td>300.02</td>
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<td>Anxiety state; other</td>
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<td>Phobia, unspecified</td>
<td>300.20</td>
<td>Social phobia</td>
<td>300.23</td>
<td>Other isolated or simple phobia</td>
<td>300.29</td>
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<tr>
<td>Neurotic depression</td>
<td>300.4</td>
<td>Separation anxiety disorder</td>
<td>309.21</td>
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### Externalizing or Disruptive Disorder: Conduct Problems, Oppositional Behavior, Aggression

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<tr>
<th>Condition</th>
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<th>Condition</th>
<th>ICD-9-CM</th>
<th>Condition</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nondependent abuse of drugs</td>
<td>305.00-305.93</td>
<td>Adjustment reaction; with predominant disturbance of conduct</td>
<td>309.3</td>
<td>Other specified disturbances of conduct, NEC; conduct disorder, childhood onset type</td>
<td>312.81</td>
</tr>
<tr>
<td>Unspecified disturbance of conduct</td>
<td>312.9</td>
<td>Oppositional disorder</td>
<td>313.81</td>
<td>Other specified counseling</td>
<td>V 65.49</td>
</tr>
</tbody>
</table>

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### Learning Disorders and Disabilities

<table>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Stammering and stuttering</td>
<td>307.0</td>
<td>Other and unspecified special symptoms or syndromes, NEC</td>
<td>307.9</td>
<td>Reading disorder, unspecified</td>
<td>315.00</td>
<td>Specific arithmetical disorder</td>
<td>315.1</td>
</tr>
<tr>
<td>Other specific learning difficulties</td>
<td>315.2</td>
<td>Developmental language disorder</td>
<td>315.31</td>
<td>Receptive language disorder (mixed)</td>
<td>315.32</td>
<td>Developmental speech or language disorder; other</td>
<td>315.39</td>
</tr>
<tr>
<td>Coordination disorder</td>
<td>315.4</td>
<td>Unspecified delay in development</td>
<td>315.9</td>
<td>Mild mental retardation</td>
<td>317</td>
<td>Moderate mental retardation</td>
<td>318.0</td>
</tr>
<tr>
<td>Severe mental retardation</td>
<td>318.1</td>
<td>Profound mental retardation</td>
<td>318.2</td>
<td>Unspecified mental retardation</td>
<td>319</td>
<td>Lack of coordination</td>
<td>781.3</td>
</tr>
<tr>
<td>Mental and behavioral problems; problems with learning</td>
<td>V40.0</td>
<td>Mental and behavioral problems; problems with communication (including speech)</td>
<td>V40.1</td>
<td>Other psychosocial circumstances; educational circumstances</td>
<td>V62.3</td>
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### Other Diagnoses

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<th>Diagnosis</th>
<th>ICD-9-CM</th>
<th>Diagnosis</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infantile autism, current or active state</td>
<td>299.00</td>
<td>Other specified early childhood psychoses, current or active state</td>
<td>299.80</td>
<td>Tic disorder, unspecified</td>
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<tr>
<td>Gilles de la Tourette disorder</td>
<td>307.23</td>
<td>Stereotyped repetitive movements</td>
<td>307.3</td>
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<td></td>
</tr>
</tbody>
</table>

### ADHD DSM-IV Coexisting Conditions

**INTERNALIZING DISORDERS**

- **Generalized Anxiety Disorder**
  - DSM-IV 300.02
  - Excessive and persistent worries ≥6 months duration affecting multiple activities and events and manifest if 3 of 6:
    1. Restlessness, feeling keyed up, on edge
    2. Being easily fatigued
    3. Difficulty concentrating, mind going blank
    4. Irritability
    5. Muscle tension
    6. Sleep disturbance

- **Major Depressive Disorder**
  - DSM-IV 296.20–296.36
  - ≥5 of 9 criteria almost every day for 2 weeks with at least depressed mood or loss of interest or pleasure:
    1. Depressed mood or irritable by subjective report or observation
    2. Markedly diminished interest or pleasure in all or almost all activities
    3. Weight loss/gain without dieting
    4. Insomnia or hypersomnia almost every day
    5. Psychomotor agitation or retardation
    6. Fatigue or energy loss
    7. Feelings of worthlessness or excessive guilt
    8. Diminished ability to think or concentrate
    9. Recurrent thoughts of death or suicide

**Other Anxiety Disorders**

- Other isolated or specific phobia DSM-IV 300.29
- Separation anxiety disorder DSM-IV 309.21
- Anxiety state, unspecified DSM-IV 300.00

**Other Depression Disorders**

- Neurotic depression DSM-IV 300.4
- Brief depressive reaction DSM-IV 309.0
- Depressive disorder, NEC DSM-IV 311
- Bereavement, uncomplicated DSM-IV V62.82

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### Mental Retardation or Learning Disabilities

<table>
<thead>
<tr>
<th>Mental Retardation</th>
<th>DSM-IV</th>
<th>Other Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild mental retardation</td>
<td>317</td>
<td>Profound mental retardation</td>
</tr>
<tr>
<td>Moderate mental retardation</td>
<td>318.0</td>
<td>Unspecified mental retardation</td>
</tr>
<tr>
<td>Severe mental retardation</td>
<td>318.1</td>
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</tr>
<tr>
<td>Reading disorder, unspecified</td>
<td>315.00</td>
<td>Other developmental or language disorder</td>
</tr>
<tr>
<td>Specific arithmetical disorder</td>
<td>315.1</td>
<td>Developmental language disorder</td>
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<tr>
<td>Other specific learning difficulties</td>
<td>315.2</td>
<td>Receptive language disorder (mixed)</td>
</tr>
<tr>
<td>Unspecified delay in development</td>
<td>315.9</td>
<td>Other and unspecified special symptoms or syndromes, NEC</td>
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<tr>
<td>Coordination disorder</td>
<td>315.4</td>
<td>Stammering and stuttering</td>
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#### Learning Disabilities or Problems

<table>
<thead>
<tr>
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<th>DSM-IV</th>
<th>Other Disorder</th>
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</thead>
<tbody>
<tr>
<td>Coordination disorder</td>
<td>315.4</td>
<td>Stammering and stuttering</td>
</tr>
</tbody>
</table>

### Externalizing Disorders

#### Oppositional Defiant Disorder

- DSM-IV 313.81

- A pattern of negative, hostile, defiant behavior for ≥ 6 months causing impairment and ≥ 4 of 8:
  1. Often loses temper
  2. Often argues with adults
  3. Often defies or refuses to comply
  4. Often deliberately annoys people
  5. Often blames others for mistakes, misbehavior
  6. Is often touchy or easily annoyed
  7. Is often angry and resentful
  8. Is often spiteful

#### Other Specified Disturbances of Conduct, NEC

- DSM-IV 312.8

- A repetitive and persistent pattern in which the basic rights of others and norms are violated with 3 criteria in past 12 months, 1 in past 6 months:

##### Aggression to people and animals

1. Often bullies, threatens, or intimidates others
2. Often initiates physical fights
3. Has used a weapon that can cause serious harm (bat, brick, broken bottle, knife, gun)
4. Has been physically cruel to people
5. Has been physically cruel to animals
6. Has stolen while confronting a victim (mugging, extortion, armed robbery)
7. Has forced someone into sexual activity

##### Destruction of property

8. Has deliberately engaged in fire setting
9. Has deliberately destroyed other’s property

##### Deceitfulness or theft

10. Has broken into someone’s house, car
11. Often lies to obtain goods or favors
12. Has stolen

##### Serious violation of the rules

13. Stays out despite parental prohibition
14. Has run away overnight more than once
15. Is often truant

#### Other Disorders

- Adjustment reaction; with predominant disturbance of conduct
- DSM-IV 309.3

- Intermittent explosive disorder
- DSM-IV 312.34

- Adjustment reaction; with mixed disturbance of emotions and conduct
- DSM-IV 309.4

---

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---

American Academy of Pediatrics

Dedicated to the Health of All Children

National Initiative for Children’s Healthcare Quality
Date __________

Attn: Case Manager

Insurance Company _______________________________________________________

Re: [Name of child or adolescent; dob]

To whom it may concern,

I saw [name of child or adolescent] on [visit date] for [diagnosis].

This letter documents the components of the services provided and billed with the diagnosis code of ___________ .

The following services were provided:

_____ Parent conference regarding the diagnosis, etiology, management, and medical treatments of [diagnosis name]. This conference lasted approximately ________ minutes.

_____ Face-to-face visit with child or adolescent for additional discussion and initiation of therapy. This visit lasted approximately ________ minutes.

_____ Correspondence to the school [name of child or adolescent] attends.

_____ Review of school records.

_____ Phone consultation(s). These consultations lasted a total of approximately ________ minutes.

_____ Other:__________________________________________________________

__________________________________________________________

Should you have any additional questions or wish these services to be coded in a different way, please contact _____________________________ in my office.

Thank you for your consideration.

Sincerely,

[Name of health professional]

ADHD Resources Available on the Internet

ADHD Information

About Our Kids
http://www.aboutourkids.org/articles/about_adhd.html

ADDitude Magazine for People With ADHD
http://www.additudemag.com

ADDvance Online Resource for Women and Girls With ADHD
http://www.addvance.com

American Academy of Family Physicians (AAFP)
http://www.aafp.org

American Academy of Pediatrics (AAP)
http://www.aap.org

American Medical Association (AMA)
http://www.ama-assn.org

Attention-Deficit Disorder Association (ADDA)
http://www.add.org

Attention Research Update Newsletter
http://www.helpforadd.com

Bright Futures
http://www.brightfutures.org

Center for Mental Health Services Knowledge Exchange Network
http://www.mentalhealth.org

Children and Adults With Attention-Deficit/Hyperactivity Disorder (CHADD)
http://www.chadd.org

Comprehensive Treatment for Attention-Deficit Disorder (CTADD)
http://www.ctadd.com

Curry School of Education (University of Virginia) ADD Resources
http://teis.virginia.edu/go/cise/ose/categories/add.html

Intermountain Health Care
http://www.ihc.com/xp/ihc/physician/clinicalprograms/primarycare/adhd.xml

National Center for Complementary and Alternative Medicine (NCCAM)
http://nccam.nih.gov

National Institute of Mental Health (NIMH)
http://www.nimh.nih.gov/publicat/adhdmenu.cfm

Northern County Psychiatric Associates
http://www.ncpamd.com/adhd.htm

One ADD Place
http://www.oneaddplace.com

Pediatric Development and Behavior
http://www.dbpeds.org

San Diego ADHD Web Page
http://www.sandiegoadhdd.com

Vanderbilt Child Development Center
http://peds.mc.vanderbilt.edu/cdc/rating~1.html

Educational Resources

American Association of People With Disabilities (AAPD)
http://www.aapd.com

Consortium for Citizens With Disabilities
http://www.c-c-d.org

Council for Learning Disabilities
http://www.cldinternational.org

Education Resources Information Center (ERIC)
http://ericir.syr.edu

Federal Resource Center for Special Education
http://www.dssc.org/frc

Internet Resource for Special Children
http://www.irsc.org

Learning Disabilities Association of America
http://www.ldanatl.org

American Association of People With Disabilities (AAPD)
http://www.aapd.com

Consortium for Citizens With Disabilities
http://www.c-c-d.org

Council for Learning Disabilities
http://www.cldinternational.org

Education Resources Information Center (ERIC)
http://ericir.syr.edu

Federal Resource Center for Special Education
http://www.dssc.org/frc

Internet Resource for Special Children
http://www.irsc.org

Learning Disabilities Association of America
http://www.ldanatl.org

National Information Center for Children and Youth With Disabilities (NICHCY)
http://www.nichcy.org

Parent Advocacy Coalition for Educational Rights (PACER) Center
http://www.pacer.org

SAMHSA
http://www.disabilitydirect.gov

SandraRief.com
http://sandrarief.com

TeachingLD
http://www.ldlce.org

US Department of Education
http://www.ed.gov

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