ADHD
REFERRAL GUIDELINE

MAINE MEDICAL PARTNERS - PEDIATRIC SPECIALTY CARE (DIV. DEVELOPMENTAL & BEHAVRIOAL PEDIATRICS) • 1577 CONGRESS ST, PORTLAND, ME • (207) 662-5522

HIGH RISK

SUGGESTED EMERGENT CONSULTATION

SYMPTOMS AND LABS

Dangerously impulsive or inattentive behavior resulting in safety threat to self or others (this will happen rarely and may be coupled with other behavioral health issues, such as mood or severe anxiety, to rise to an urgent level)

SUGGESTED PREVISIT WORKUP

Urgent concerns warrant a Crisis call or emergent psychiatric evaluation, after obtaining a history of safety concerns

Forwarding previous psychological, psychiatric, etc assessments and school records (IEP, 504 plan, SPED testing) provides helpful information to assessing specialist

For a child with suspected but not previously diagnosed ADHD, obtain Vanderbilt or Conners questionnaires from parents and teachers

MODERATE RISK

SUGGESTED CONSULTATION OR CO-MANAGEMENT

SYMPTOMS AND LABS

ADHD that has already been assessed and treated by PCP but without satisfactory outcome, with ongoing significant impact on function at home or school

OR

ADHD (diagnosed or suspected) in a child with a co-morbid developmental disability or significant complicating medical or psychosocial factors (initial evaluation and treatment by PCP is still recommended)

SUGGESTED WORKUP

For new diagnostic concern: Vanderbilt or Conners questionnaires from parents and teachers. For ongoing management of previously diagnosed child, use Vanderbilts or Clinical Attention Problem Scales

Obtain previous psychological, psychiatric, etc. assessments and school records (IEP, 504 plan, SPED testing). Call teachers or ask for written description of concerns

When referring to DBPeds or Psychiatry- specify services needed (diagnosis, med management, parent guidance, educational advocacy) to facilitate collaborative care

LOW RISK

SUGGESTED ROUTINE CARE

SYMPTOMS AND LABS

Typical ADHD symptoms per DSM5- this is considered appropriate to be addressed by PCP

SUGGESTED MANAGEMENT

To make diagnosis: Vanderbilt or Conners questionnaires from parents and teachers. Obtain school records (IEP, 504 plan, SPED testing)-need 6 or 9 symptoms rated Often or Very Often from either Inattention list or Hyperactive/Impulsive list or from each list. Need symptoms in more than 1 setting

Management includes behavioral guidance by PCP or counselor/social worker and medication is often helpful, following current AAP guidelines (ref below)

Obtain previous psychological, psychiatric, etc assessments and school records (IEP, 504 plan, SPED testing). Call teachers or ask for written description of concerns

Diagnosis and care through Medical Home following current AAP guidelines. See also MMP DBPeds algorithms for diagnosis and treatment of ADHD available via enclosed addendums

CLINICAL PEARLS

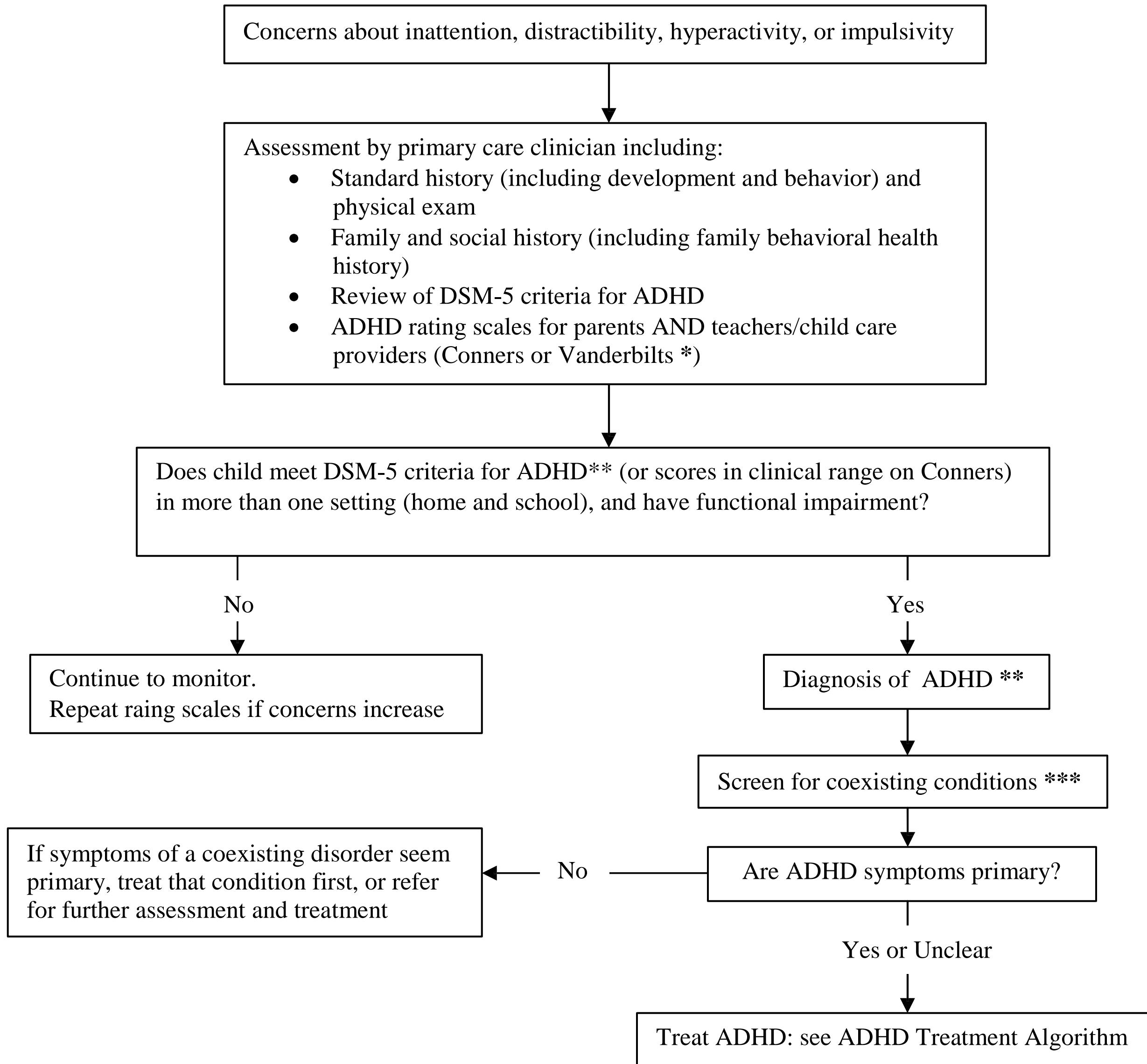
- Screen for co-existing conditions such as anxiety, mood issues, learning issues, trauma exposure. If ADHD symptoms are primary, or it is unclear consider treating ADHD first. If another conditions seems primary consider treating or referring for that condition.
- Medications that can be managed by PCP, depending on comfort level include psychostimulants, guanfacine, atomoxetine, buproprion.
- Prior to starting stimulants screen for cardiac risk: personal or family history of arrhythmias, syncope, dyspnea with exertion, or family history of sudden death.
- Collect data from teachers before and after starting meds, and with med changes, to monitor response- suggest using f/u Vanderbilts or Clinical Attention Problem Scales (both available free in the public domain by on-line search).
- References:

  - *1. AAP Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents.. Pediatrics. November 2011, VOLUME 128 / ISSUE 5. Available at http://pediatrics.aappublications.org/content/128/5/1007*
  - *2. Daughton JD and Kratochvil CJ, 2009. Review of ADHD Pharmacotherapies: Advantages, Disadvantages and Clinical Pearls, J Am Child Adol Psych, 48(3): 240-248*

Maine Medical
PARTNERS

These clinical practice guidelines describe generally recommended evidence-based interventions for the evaluation, diagnosis and treatment of specific diseases or conditions. The guidelines are: (i) not considered to be entirely inclusive or exclusive of all methods of reasonable care that can obtain or produce the same results, and are not a statement of the standard of medical care; (ii) based on information available at the time and may not reflect the most current evidenced-based literature available at subsequent times; and (iii) not intended to substitute for the independent professional judgment of the responsible clinician(s). No set of guidelines can address the individual variation among patients or their unique needs, nor the combination of resources available to a particular community, provider or healthcare professional. Deviations from clinical practice guidelines thus may be appropriate based upon the specific patient circumstances.

ADHD ASSESSMENT



* Conners Parents and Teachers Rating Scales-Revised available for purchase at ; http://psychcorp.pearsonassessments.com
Vanderbilt scales free online at: http://www.nichq.org/resources/adhd_toolkit.html
AAP ADHD Toolkit available for purchase at: www.aap.org

**Hyperactive-Impulsive type, Inattentive Type or Combined type (at least 6/9 symptoms present 'often or very often' from the Hyperactive-Impulsive list, or the Inattentive list, or 6/9 from each list for Combined type)

*** Anxiety, Depression, Learning Disorder

References:

AMERICAN ACADEMY OF PEDIATRICS: Clinical Practice Guideline: Diagnosis and Evaluation of the Child With Attention-Deficit/Hyperactivity Disorder PEDIATRICS Vol. 105 No. 5 May 2000, pp. 1158-1170

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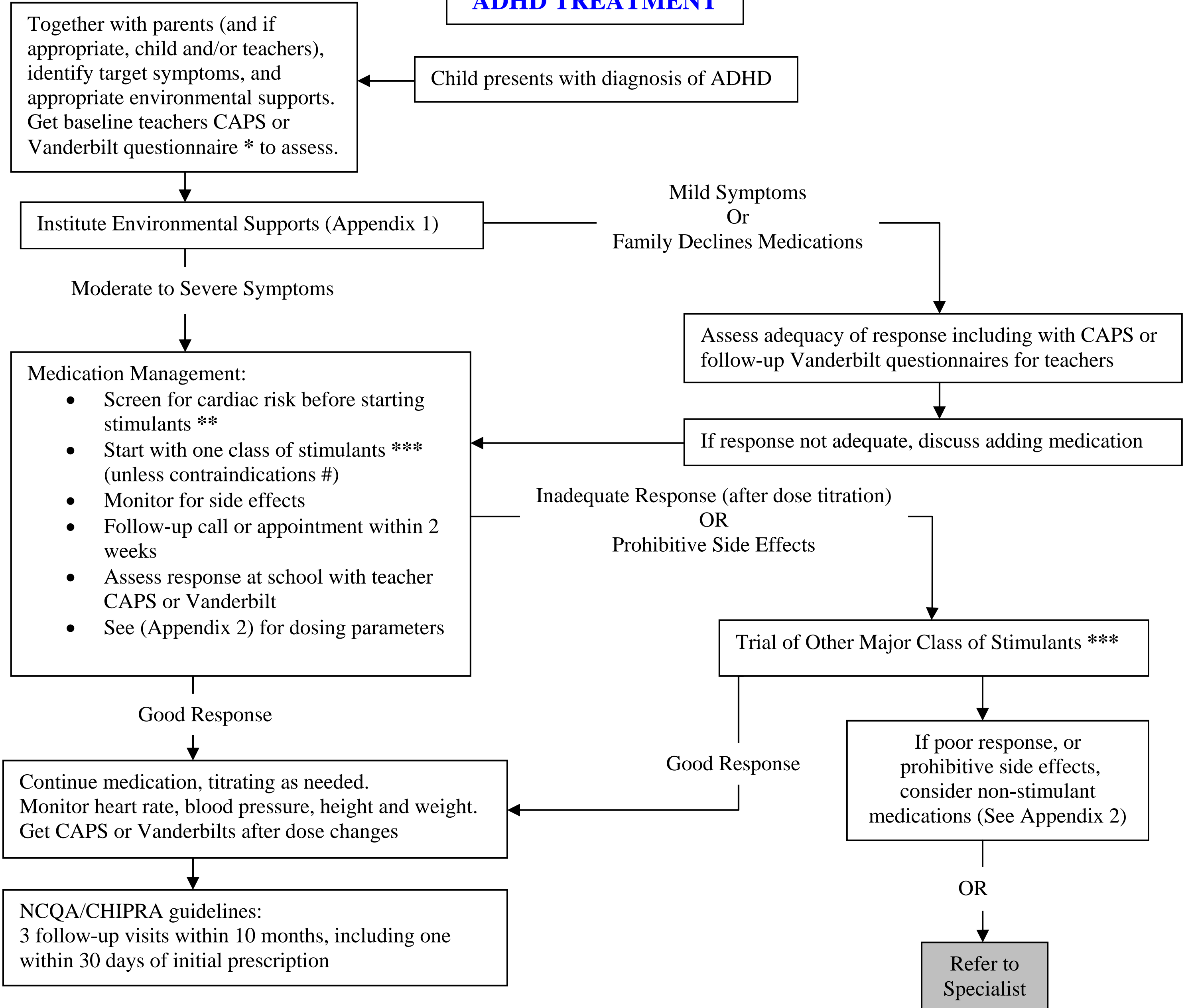
ADHD TREATMENT



* Clinical Attention Problem Scale available at: www.dbpeds.org
Vanderbilt follow-up questionnaire available at: http://www.nichq.org/resources/adhd_toolkit.html
** Personal history of syncope, arrhythmia, dizziness with exertion; family history of syncope, arrhythmia, or sudden death
*** The two classes of stimulants are methylphenidate-based or amphetamine-based (see Appendix 2 for details)
#Glaucoma, substance abuse, arrhythmia or structural cardiac abnormality (needs Cardiology Clearance)

REFERENCES:

- American Academy of Child and Adol Psychiatry. July 2007. Practice Parameter for the Assessment and Treatment of Chldren and Adol with AD/HD, J Am Acad Child Adolesc Psychiatry, 46:7,
- American Academy of Pediatrics. October 2001. Clinical Practice Guideline: Treatment of the School-Aged Child With Attention-Deficit/Hyperactivity Disorder, Pediatrics 108: 1033-1044.
- www.ncqa.org National Committee for Quality Assurance
- The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009

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Supplement to Guideline
Use of Commonly Prescribed Psychostimulants

Medication	Brand Name(s)	Starting dose (mg/d)	Usual dosage (mg/d)	How Supplied	Maximum dose (mg/d)	Generic
Dextroamphetamine	Dextrostat	2.5 mg-increasing dosage- may need AM and midday	Child 5-20 mg/qd (approx 0.5mg/kg/day)	5,10 mg tab (dextrostat, short-acting)	40 mg	Y
	Dexedrine spansules	5 mg-increasing Dosage, in AM only	Adult +/- 20-45 mg/d	5,10,15 mg spansules		Y
Lysdexamfetamine	Vyavanse	20-30 mgs	30-70 mgs	20, 30, 40, 50, 60, 70 mg tabs	70 mg	N
Dextroamphetamine Mix	Adderall	2.5-5 mg po am	Child 5-40 mg qd (approx 0.75mg/kg/day) Adult 5-60 mg qd	5,7.5,10,12.5,15,20,30 mg 10,20,30 mg XR tabs	40 mg child 60 adult	Y
	Adderall XR	5-10 mg child 10-20 mg adult	10-30 child (approx 0.75mg/kg/day) 10-40 adult	5,10, 15, 20, 25, 30 mg caps	60 mg	N
Dexmethylphenidate	Focalin	2.5 mg AM and midday	2.5-10 mg po qd for child over six years (approx 0.5mg/kg/day)	2.5, 5, 10 mg	20mg/qd	Y
	Focalin XR	2.5 - 5 mg Child 5 mg Adult	5-20 mg for both children and adults	5, 10, 15, 20 mg caps	20 mg	N
Methylphenidate	Ritalin	5-10 mg child	Child 10-35 mg daily (approx 1mg/k/day for all forms of methylphenidate)	5,10,20 mg tabs	35 mg qd	Y
	Ritalin SR	10-20 mg qAM		20 mg SR	60 mg qd	Y
	Ritalin LA	10-20 child/adult	Child 20-60 mg qAM	10, 20, 30, 40 caps	60 mg	N
	Metadate	10-20 mg qam	20-40 mg qAM	10, 20 mg ER tab	60 mg qd	Y
	Concerta	18 mg qd	20-60 mg qAM	18,27,36,54 mg SR tabs	54 mg qd	Y
	Daytrana Patch	5-10 mgs	18-54 mg-1 patch qd	10, 15, 20, 30 mgs		N
	Metadate CD	10-20 mgs qam	1-20 mgs	10, 20, 30 mgs		N
	Methylin	5-10 mgs	10-60 mgs	5, 10, 20 mgs		Y
	Methylin ER	10-20 mgs	10-35 mgs	10, 20 mgs		Y
	Methylin Chewable	2.5-5 mgs	10-40 mgs	2.5, 5, 10 mgs		N
	Methylin Soln	5 mgs	10-30 mgs	5, 10 mgs per teaspoon		N

Use of non-stimulants

Medication	Brand Name(s)	Starting dose (mg/d)	Usual dosage	How Supplied	Max dose (mg/d)	Generic
Atomoxetine HCL	Strattera	40-62lbs 18 mg 63-93lbs 25 mg 94-126lbs 40 mg 127+lbs 40 mg	40-62lbs 25 mg 63-93lbs 40 mg 94-126lbs 60 mg 127+lbs 80 mg	10, 18, 25, 40, 6 0mg	Child 1.4 mg/kg or 100 mg or whichever is less Adult 100 mg	N
Guanfacine	Tenex	0.5 to 1 mg qd -tid	0.5mg to 1mg bid or tid (monitor BP)	1mg, 2mg		N (Short Acting Generic)
Guanfacine Extended Release	Intuniv	1mg qd	1 – 4 mg qd	1, 2, 3, 4 mg	4 mg	

Additional information

Dosage is individualized for each patient.
Upward titration should continue weekly until increments of improvement stop or side effects become significant. If there is no improvement at a dose that produces noticeable side effects the medication should be discontinued.
Common side/effects include insomnia, nervousness, and are usually dose dependant. Additional side effects include headache, palpitations, decreased appetite, and nausea.
Careful supervision is required for medication withdrawal.
Patients taking Strattera (atomoxetine) should be informed of increased risk of irritability, suicidal ideation or liver toxicity.

Updated August 2011

Appendix 1: Behavioral Interventions/Environmental Supports

School:
- Appropriate educational placement
- Classroom seating away from distractions
- Motor breaks
- Signal system with teacher
- Simple, straightforward directions, break tasks down into steps
- Visual supports (checklists, reminders, written instructions)
- Organizational support (desk, locker, backpack, materials to bring home, prioritizing homework, 2nd set of textbooks at home)
- Extra staff support- eg to check backpack
- Frequent, consistent feedback including positive incentives and consequences
- Good school/parent communication: daily notebook
- Work on strengths and self-esteem, not just areas in need of improvement
- May warrant a 504 support plan with formal accommodations

Home:
- Positive "special time" with parents, daily if possible
- Increase positive feedback for good behavior, including incentive system
- Structure home environment- timers, charts, sequence activities for the child
- Appropriate, consistent, immediate discipline: sticker charts, remove privileges, time outs
- Limit over-stimulating experiences (eg shopping)
- Consider hiring an ADHD coach
- Individual counseling- valuable for secondary effects (self-esteem, social issues) and for comorbidities
- Family therapy

What children can learn to do:
- Ask teacher to repeat instructions
- Use a master notebook/planner
- Break down tasks and make lists and schedules
- Take notes during class and while reading
- Do homework in a quiet area
- Do one thing at a time
- Have good sleep habits
- Get regular exercise