2010 Screening, Referral and Treatment for Adult Attention-Deficit and Hyperactivity Disorder (ADHD) in a Primary Care Setting

The Clinical Practice Guideline for 2010 Screening, Referral and Treatment for Adult Attention Deficit and Hyperactivity Disorder (ADHD) in a Primary Care Setting was reviewed and approved by Unity's Clinical Quality Improvement Committee (CQIC) on November 19, 2010. The guideline had previously been approved by CQIC on November 21, 2008 and November17, 2006. The UW Medical Foundation, UW Hospital and Clinics, UW Health Department of Family Medicine and Internal Medicine, UW Behavioral Health, Unity Health Insurance, and Group Health Cooperative participated in the development and revision of this guideline. The task force was a multidisciplinary work group comprised of physicians, behavioral health practitioners, a pharmacist, and quality improvement staff.

2010 SCREENING, REFERRAL AND TREATMENT FOR ADULT ATTENTION DEFICIT AND HYPERACTIVITY DISORDER (ADHD) IN A PRIMARY CARE SETTING

Guidelines are designed to assist clinicians by providing a framework for the evaluation and treatment of patients. This guideline outlines the preferred approach for most patients. It is not intended to replace a clinician's judgment or to establish a protocol for all patients. It is understood that some patients will not fit the clinical condition contemplated by a guideline and that a guideline will rarely establish the only appropriate approach to a problem.

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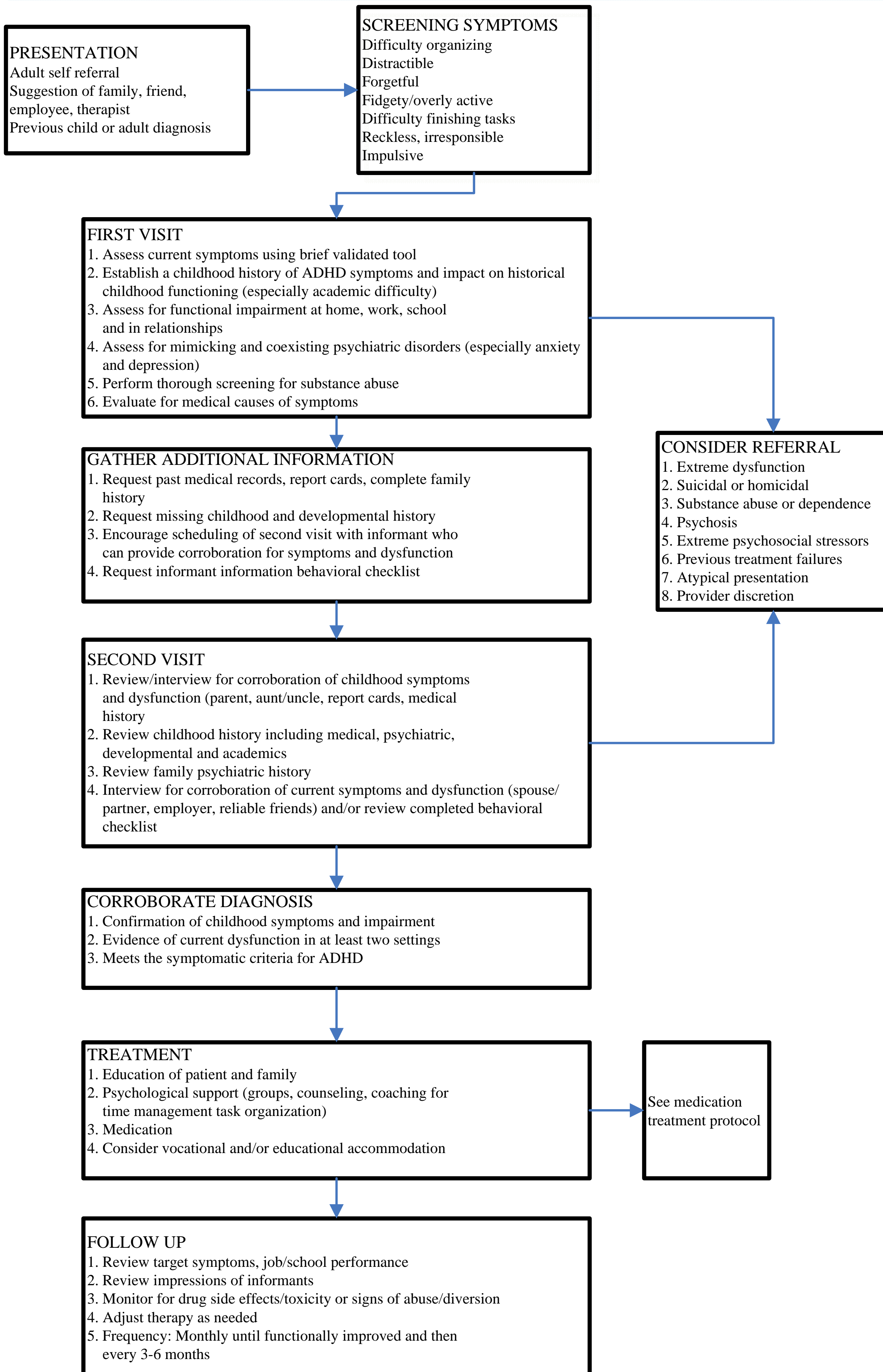
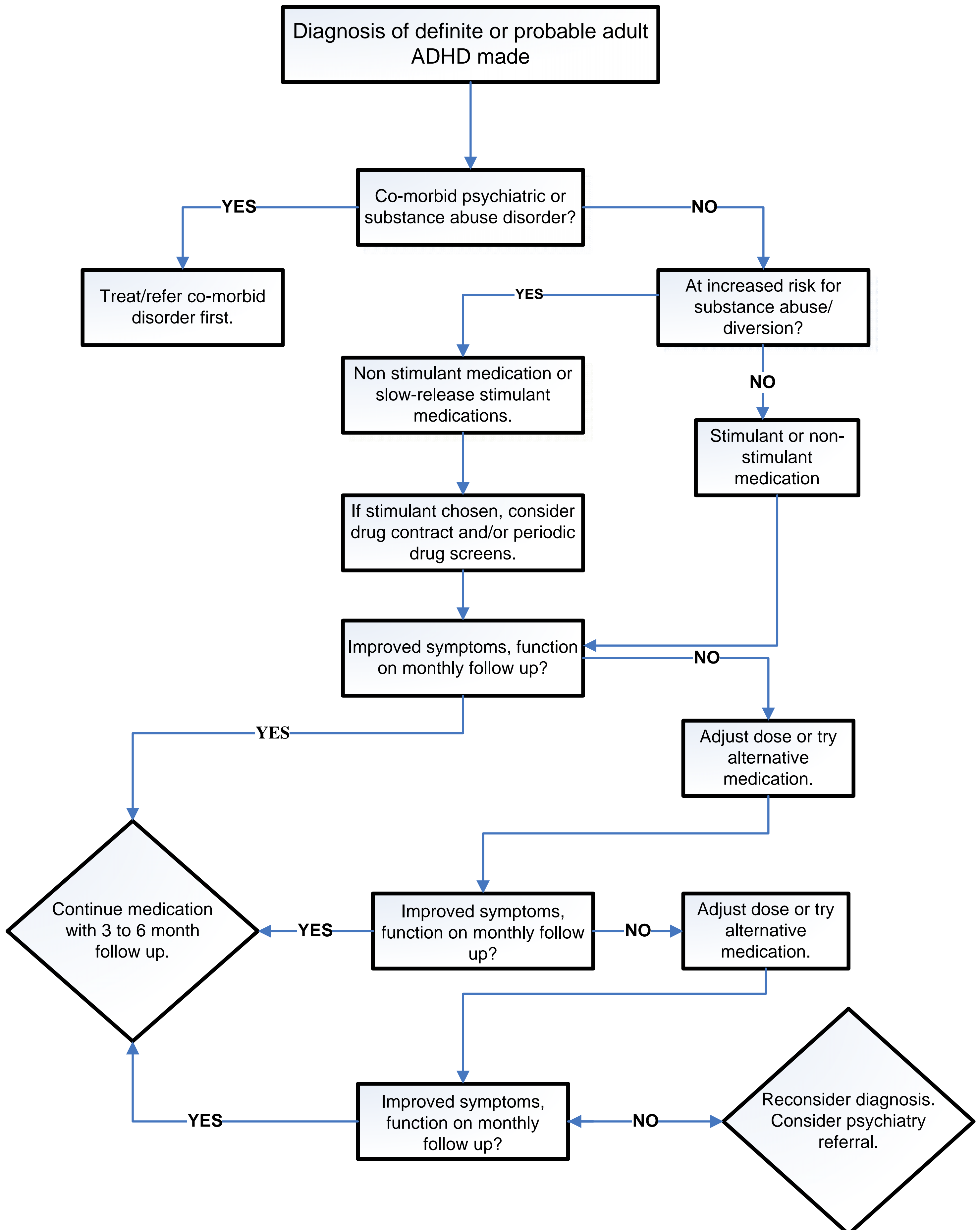
Adult ADHD Protocol (Ages 18 +)




Adult ADHD Medication Protocol
Diagnosis of definite or probable adult ADHD made
Co-morbid psychiatric or substance abuse disorder?
YES
Treat/refer co-morbid disorder first.
NO
At increased risk for substance abuse/ diversion?
YES
Non stimulant medication or slow-release stimulant medications.
If stimulant chosen, consider drug contract and/or periodic drug screens.
NO
Stimulant or non-stimulant medication
Improved symptoms, function on monthly follow up?
NO
Adjust dose or try alternative medication.
YES
Continue medication with 3 to 6 month follow up.
YES
Improved symptoms, function on monthly follow up?
NO
Adjust dose or try alternative medication.
YES
Improved symptoms, function on monthly follow up?
NO
Reconsider diagnosis. Consider psychiatry referral.

Adult ADHD Introduction

Attention Deficit Hyperactivity Disorder (ADHD), originally thought to occur just in childhood, is now widely understood as persisting into adulthood. Between 50 to 65 percent of adults diagnosed with childhood ADHD will continue to have symptoms of inattention, distractibility and impulsivity causing functional impairment as adults. In addition, adults who were never diagnosed as children may present with a complicated array of behavioral, legal and functional problems requesting diagnosis and treatment. The Diagnostic Statistical Manual (DSM) childhood criteria have not been validated for adults and the symptom lists are questionably appropriate in terms of adult development and thresholds. The DSM-IV-TR criteria for ADHD require that symptoms have been present as a child (even if an official diagnosis was not given as a child). Without clear consensus for diagnosis and with the high prevalence of co morbid psychiatric disorders, the primary care clinician is often unsure of the best approach for initial assessment.

This guideline is designed to provide primary care clinicians with a structure, tools and referral criteria for diagnosis and treatment of adults 18 and over with symptoms typical of ADHD.

Presentation and Screening

Adults with potential ADHD may present with a self-diagnosis, at the suggestion of a family member, friend, employer or therapist or with other behavioral or psychological problems. There may or may not be a previous childhood or adult diagnosis of ADHD.

Adult ADHD is characterized by chaotic lifestyle. Indicators of ADHD and screening symptoms include:

- Inattention
- Restlessness
- Forgetfulness
- Poor executive functioning
- Disorganization
- Impulsive behaviors
- Poor planning
- Difficulty parenting

High risk behaviors, failed relationships, legal difficulties, substance abuse and recurrent job loss are common. Physical hyperactivity diminishes in severity with age, but inattentive symptoms become more prominent and may be perceived as incompetence. Some adults compensate by finding a spouse / partner who organizes them or a job which is very active, highly absorbing or stimulating.

Structure of the Assessment Process

Evaluation of adults presenting with ADHD symptoms requires at least two visits. As well as allowing for a thorough evaluation, two visits allow the clinician to assess motivation for follow-up, persistence of symptoms and dysfunction and likelihood for alternative diagnoses. The following components of a complete evaluation are considered during both visits:

- review and corroboration of current symptoms and dysfunction
- determination of a childhood onset
- evaluation for comorbid and /or mimicking psychiatric problems, medical disorders or substance abuse.

First Visit

1. Review Current Symptoms and Functional Impairment

A. DSM-IV-TR ADHD criteria should be used and followed. A validated adult ADHD reading scale may be used to adjunctively evaluate an adult patient.

B. Patients may not connect their symptoms to functional impairment so it may be necessary to inquire why they have been recurrently fired (disorganization, couldn't complete tasks), relationships (insensitivity, couldn't listen, interrupting), legal problems (motor vehicle accident (MVA), speeding, impulsive stealing or fighting).

2. Establish Onset

A. ADHD does not have an adult onset. If the patient does not remember difficulties in school or at home in childhood then the clinician should investigate an alternative diagnosis.

3. Perform Medical Evaluation

A. Screen for medical, psychiatric or substance abuse issues which could explain or exacerbate symptoms of ADHD (perinatal anoxia, prenatal maternal substance abuse, lead poisoning, seizures, head trauma, hyperthyroidism, atrial fibrillation).

B. Screen for medical conditions which would influence choice of medication (cardiac compromise, arrythmias, liver damage, glaucoma). When considering a stimulant in an adult with risk factors for cardiac disease, the provider should consider ordering an EKG.

C. Establish baseline vital signs: height, weight, blood pressure, pulse.

D. Laboratory testing should be limited to areas of concern, such as TSH.

Gather Additional Information

1. Historical Information

Most patients with adult ADHD will not know their complete family or personal history and are unlikely to come with old records. It is important to seek corroboration of childhood symptoms and impairment. Old medical records, report cards or interviews with parents or close family members are the main sources for childhood medical and academic history. A complete family history, including psychiatric disorders or other familial family disorders (sudden death, cardiac disorders) which could influence consideration of diagnosis or choice of medications should be sought.

2. Current Symptom Corroboration

It is also important to have corroboration of current symptoms and dysfunction. Scheduling the second visit with an informant, such as a spouse, partner, friend or parent, can be very helpful in obtaining more detail about patient concerns. Phone interviews or completion of adult symptom scales by a close observer can be used as an alternative to attending a patient visit.

Second Visit and Evaluation

The second visit is spent primarily on reviewing records and corroborative information. If these materials and the patient's presentation are consistent with adult ADHD, the clinician can begin forming a treatment and follow-up plan as well.

1. Corroborate Childhood Onset and Impairment

Childhood history can be gathered by review of medical records, review of report cards or other academic materials, and interview with parents or close family member either in person or via phone call. High activity patterns, difficult temperament, and frequent accidents or risk taking behavior are common childhood characteristics. Review of academic background should reveal areas of impairment or concern. Look for drop outs, failures, learning disability, special evaluations or classes, suspensions / expulsions, and focused problems in areas such as reading, writing, penmanship or math. Review of report cards often indicates behavior problems, lack of expected achievement, incomplete work, or inadequate effort. If there is no objective evidence of childhood symptoms and impairment, the diagnosis of adult ADHD should be reconsidered.

2. Review Family Psychiatric History

It is common to have a positive family psychiatric history. Inquire particularly about learning disabilities, behavior problems, legal difficulties, ADHD, and substance abuse.

3. Consider Psychiatric Diagnosis

Psychiatric disorders can cause inattentive symptoms or can influence the course of treatment. Presence of another psychiatric diagnosis does not preclude a diagnosis of adult ADHD but it does make diagnosis and treatment more confusing. Significant physical, verbal or emotional abuse / neglect can contribute to symptoms characteristic of ADHD. Depression, bipolar disorder, anxiety, personality disorders, substance abuse and other psychiatric disorders should be considered as a part of the evaluation. Untreated depression and anxiety are particularly common reasons why patients present with complaints about concentration. To help clarify the situation, the provider can ask if concentration improves when the patient is feeling less anxious or depressed. (i.e., ADHD tends not to fluctuate with time, whereas anxiety and depression do). Patients whose psychiatric

status is unclear should be referred to mental health. Patients with active substance abuse should be referred to an Alcohol and Other Drug Abuse (AODA) program.

Referral

Referral to psychiatrists and additional providers is always at the discretion of the provider.

There are several presentations and co-conditions for which referral is recommended:

1. Extreme dysfunction
2. Suicidal or homicidal
3. Substance abuse or dependence
4. Psychosis
5. Extreme psychosocial stressors
6. Previous treatment failures
7. Atypical presentation – if presentation as brand new symptoms this is not ADHD, even if not diagnosed as a child the symptoms must concur
8. Provider discretion

A list of suggested referral sources are provided near the end of this document.

Establish Diagnosis

1. For a diagnosis of ADHD, symptoms of hyperactivity/impulsivity and/or inattention should:
    - Meet the diagnostic criteria in Diagnostic and Statistical Manual of Mental Disorders 4th edition (DSM-IV-TR)
    - Be associated with at least moderate current psychological, social, and/or educational or occupational impairment based on interview and/or direct observation in multiple settings, **and**
    - Be pervasive, occurring in two or more important settings including social, familial, educational and/or occupational settings and need to have been childhood onset.

2. It is important to identify co-morbid disorders because:
    a. psychiatric conditions should be addressed prior to starting treatment for ADHD.
    b. certain medical conditions (liver disease, seizures, hypertension, glaucoma) are relative contraindications to certain ADHD medications. See medication section.
    c. they may change the expected outcome of treatment.

Treatment

1. Provide or offer referral for full education regarding ADHD symptom management and coping strategies for both the patient and family.
2. Offer psychological support as needed through group therapy or counseling. Some patients may have grief and anger issues due to lost opportunities when diagnosis is made in adulthood.
3. Adults with ADHD who are also parents may benefit from psychoeducation to assist them with parenting skills.
4. Provide or offer referral for skills training in the areas of finances, communication, time management and task organization. Some adults benefit from psychotherapy to focus on psychoeducation and effective coping strategies for managing ADHD symptoms.
5. Consider vocational and/or educational accommodation.
6. Follow medication treatment protocol. Adults are better able to adhere to regimens with long acting formulations. Side effects tend to decrease in severity over the first 3 months of use. Data are unavailable regarding pros and cons of drug holidays or intermittent use. Specific patient needs or wishes should be considered and therapy should be individualized.
7. In situations where there is increased risk of substance abuse or diversion, non stimulant preparations or slow release stimulants are strongly preferred. Slow release stimulant preparations should be used with some caution as they still offer some risk of abuse or diversion. When crushed, they more closely resemble immediate release preparations in terms of onset and effect.
8. For patients at high risk of substance abuse, consider establishing a drug contract or conducting periodic drug screens.

Referral Sources

The following groups can assist those in the UW Health system with resources and referral options outside of the primary care setting.

If you are unsure of where to direct a patient or need additional assistance determining referral options for your patient, UW Health Patient Relations/Social Services is the internal department that can help you and the patient determine options.

Patient Resources
7974 UW Health Court
Middleton, WI 53562
608.821.4819

Additionally The UW Health Behavioral Health Consultation Systems provides referral management, prior authorization, and concurrent case review for Physicians Plus Insurance Corporation HMO members and Unity Health Insurance members. Gateway Recovery provides the management for alcohol and other drug abuse (AODA) services for Unity and GHC members.

UW Behavioral Health
6001 Research Park Blvd
Madison, WI 53719
800.683.2300
608.282.8960 (local in Madison)

Gateway Recovery
25 Kessel Court, Suite 200
Madison, WI 53711
608.278.8200 (local in Madison)

NewStart
1015 Gammon Lane
Madison, WI 53719
608.417.8144 (local in Madison)

Follow-up Care

Adults with a new diagnosis, uncontrolled symptoms or change in medication should be seen within 30 days by a clinician who can assess for side effects and adjust medication if needed. Monthly contacts or visits should be routine until functionality is significantly improved. Once functionality is improved, follow-up appointments every 3 to 6 months are recommended. Informants should be included, as available, in follow-up sessions.

At each follow-up visit:

1. Review should specifically include diurnal variation in symptoms, as this informs recommendations for change in timing/formulation of the medications prescribed.
2. Review target symptoms, job/school performance, relationship issues.
3. Monitor for adherence to therapy, drug side effects/toxicity or signs of abuse/diversion. Also monitor vital signs to assess for increases in blood pressure and pulse.
4. Review impressions of informants.
5. Adjust therapy as needed.

Screening Tools

The Adult AHDH Self-Report Scale (ASRS v1.1) Symptom Checklist and Screening tool and the Massachusetts ADHD Rating Scale can be used without copyright permission or cost. The Adult ADHD Self-Report Scale (ASRS v1.1) is attached to this document.

Attachment

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist and Screening tool
Massachusetts ADHD Rating Scale

Acknowledgement

This guideline was initially developed in 2006 by a collaborative UW Health work group. Members of the work group included staff from the Departments of Family Medicine and Internal Medicine, UW Medical Foundation, UW Hospital and Clinics, Behavioral Health Consultation Systems, Unity Health Insurance, Physicians Plus Insurance Corporation and Group Health Cooperative. Questions, comments or requests for additional information should be directed to Kevin Straka, MS, MBA, UW Health Center for Clinical Knowledge Management at kstraka@uwhealth.org or 608-890-6698

Evidence and References

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6. Searight, Russell, Burke, John and Fred Rottnek, Adult ADHD: Evaluation and Treatment in Family Medicine. Am Fam Physician 2000; 62: 2077-86.
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10. National Collaborating Center for Mental Health, Attention deficit hyperactivity disorder. Diagnosis and management of ADHD in children, young people and adults. London (UK): National Institute for Health and Clinical Excellence (NICE)' 2008 Sep. 59 p (Clinical guideline; no. 72).
11. Surman Craig BH. ADHD in Adults. Medscape 2005

Medications used in the Treatment of Attention-Deficit/Hyperactivity Disorder

GENERAL CONSIDERATIONS FOR STIMULANTS

- Consider cardiac risk factors before initiating therapy
- Use cautiously if history of tics
- Give with/after food and swallow whole with liquids
- Longer-acting stimulants may have greater problematic effects on evening appetite and sleep
- Use cautiously if history of substance abuse or diversion concern
- Monitor patient weight and vital signs
- Pellet/beaded capsule formulation may be opened & sprinkled on soft food
- Nonabsorbable tablet shell may be seen in stool (Concerta)
- Consider full cardiovascular evaluation before initiating therapy

Methylphenidate Products

	Product Names	Duration of Action	Strengths Available (in mg)	Usual Dosing
Short acting	methylphenidate* methylphenidate (Methylin) (equivalent to Ritalin)*	4 hours or less	5, 10, 20 2.5, 5, 10, 20 10mg/5mL and 5mg/5mL solutions	5-20mg 2-3 times daily
Intermediate acting 4-6 hours	methylphenidate SR* methylphenidate (Methylin ER) (equivalent to Ritalin SR)* methylphenidate (Metadate ER) dexmethylphenidate (Focalin)* caps	4 – 6 hours	20 10, 20 10, 20 2.5, 5,10	20-40mg in morning and 20 20 mg in early afternoon 20-60 mg daily 5mg 2 times daily
Intermediate acting 6-8 hours	methylphenidate (Metadate CD) caps (30/70) **methylphenidate (Ritalin LA) caps (50/50)	6 – 8 hours 6 – 8 hours	10, 20, 30, 40, 50, 60 10, 20, 30, 40	10-60mg once daily 20-60mg once daily
Long acting	dexmethylphenidate (Focalin XR)** capsmethylphenidate (Daytrana) patch methylphenidate (Concerta) tabs (22/78)**	10-12 hours 12 hours (with 2 -3 hour delay) 10 hours	5, 10, 20, 30, 40 10, 15, 20, 30 18, 27, 36, 54	5-20 mg once daily 10-30mg patch daily 18-54mg once daily

* Generic product
** Oral long acting methylphenidate products have immediate release and extended release components. Vary by product.

Amphetamine Products

	Product Names	Strengths Available (in mg)	Usual Dosing
Short acting	dextroamphetamine sulfate*	5, 10	5-15 mg 2 times daily OR 5-10 mg daily
Intermediate acting	dextromphetamine SR Dexedrine spansules ** amphetamine salt combo (Adderall) *, **	5, 10, 15 5, 10, 15 5, 7.5, 10, 12.5, 15, 20, 30	5-30mg daily OR 5-15mg 2 times daily 5-30mg 1-2 times daily
Long acting	amphetamine salt combo / Adderall XR* lisdexamfetamine (Vyvanse) **	5, 10, 15, 20, 25, 30 20, 30, 40, 50, 60, 70	10-30mg once daily 20-70mg once daily

* Generic product
** Oral long acting methylphenidate products have immediate release and extended release components. Vary by product.

GENERAL CONSIDERATIONS FOR NON- STIMULANTS

- May be used in cases if history of tics worsening from stimulants
- Monitor patient weight and vital signs
- Consider cardiovascular risk factors before initiating therapy and evaluate further if needed
- Medication of choice if concern about abuse or diversion
- Atomoxetine (Strattera) can cause liver damage in rare cases
- Consider initiation with lower doses to improve tolerability
- Give with/after food and swallow whole with liquids
- Also effective for some sleep disturbances, except bupropion
- Taper off to avoid rebound hypertension for clonidine or guanfacine
- Avoid bupropion if history of seizure disorders
- Monitor closely for suicidal ideation with atomoxetine, tricyclics and bupropion

Non-Stimulant Products

	Product Names	Strengths Available (in mg)	Usual Dosing
Anti-depressants	nortriptyline (Pamelor Aventyl) *	10, 25, 50, 75, 10mg/mL soln	Doses vary: 1-3 times daily
	bupropion (equivalent to Wellbutrin) tab	75, 100	50-100mg 3 times daily
	bupropion SR (equivalent to Wellbutrin SR)*	100, 150, 200	100-150mg 2 times daily
	bupropion XL (equivalent to Wellbutrin XL)*	150, 300	150-300mg once daily
Other	atomoxetine (Strattera)	10, 18, 25, 40, 60, 80, 100	40mg starting dose, 40-100mg daily
	clonidine (Catapres)*	01., 0.2, 0.3	0.1 – 0.2 mg 1-2 times daily
	guanfacine (equivalent to Tenex)*	1, 2	0.5 – 2 mg 2 times daily
	guanfacine XR* (Intuniv)	1, 2, 3, 4	1-4 mg once daily

*Generic product

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist Instructions

The questions on the back page are designed to stimulate dialogue between you and your patients and to help confirm if they may be suffering from the symptoms of attention-deficit/hyperactivity disorder (ADHD).

Description: The Symptom Checklist is an instrument consisting of the eighteen DSM-IV-TR criteria. Six of the eighteen questions were found to be the most predictive of symptoms consistent with ADHD. These six questions are the basis for the ASRS v1.1 Screener and are also Part A of the Symptom Checklist. Part B of the Symptom Checklist contains the remaining twelve questions.

Instructions:

Symptoms

1. Ask the patient to complete both Part A and Part B of the Symptom Checklist by marking an X in the box that most closely represents the frequency of occurrence of each of the symptoms.

2. Score Part A. If four or more marks appear in the darkly shaded boxes within Part A then the patient has symptoms highly consistent with ADHD in adults and further investigation is warranted.

3. The frequency scores on Part B provide additional cues and can serve as further probes into the patient's symptoms. Pay particular attention to marks appearing in the dark shaded boxes. The frequency-based response is more sensitive with certain questions. No total score or diagnostic likelihood is utilized for the twelve questions. It has been found that the six questions in Part A are the most predictive of the disorder and are best for use as a screening instrument.

Impairments

1. Review the entire Symptom Checklist with your patients and evaluate the level of impairment associated with the symptom.

2. Consider work/school, social and family settings.

3. Symptom frequency is often associated with symptom severity, therefore the Symptom Checklist may also aid in the assessment of impairments. If your patients have frequent symptoms, you may want to ask them to describe how these problems have affected the ability to work, take care of things at home, or get along with other people such as their spouse/significant other.

History

1. Assess the presence of these symptoms or similar symptoms in childhood. Adults who have ADHD need not have been formally diagnosed in childhood. In evaluating a patient's history, look for evidence of early-appearing and long-standing problems with attention or self-control. Some significant symptoms should have been present in childhood, but full symptomology is not necessary.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
					Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					
					Part B

The Value of Screening for Adults With ADHD

Research suggests that the symptoms of ADHD can persist into adulthood, having a significant impact on the relationships, careers, and even the personal safety of your patients who may suffer from it.[1-4] Because this disorder is often misunderstood, many people who have it do not receive appropriate treatment and, as a result, may never reach their full potential. Part of the problem is that it can be difficult to diagnose, particularly in adults.

The Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist was developed in conjunction with the World Health Organization (WHO), and the Workgroup on Adult ADHD that included the following team of psychiatrists and researchers:

- **Lenard Adler, MD**
  Associate Professor of Psychiatry and Neurology
  New York University Medical School

- **Ronald C. Kessler, PhD**
  Professor, Department of Health Care Policy
  Harvard Medical School

- **Thomas Spencer, MD**
  Associate Professor of Psychiatry
  Harvard Medical School

As a healthcare professional, you can use the ASRS v1.1 as a tool to help screen for ADHD in adult patients. Insights gained through this screening may suggest the need for a more in-depth clinician interview. The questions in the ASRS v1.1 are consistent with DSM-IV criteria and address the manifestations of ADHD symptoms in adults. Content of the questionnaire also reflects the importance that DSM-IV places on symptoms, impairments, and history for a correct diagnosis.[4]

The checklist takes about 5 minutes to complete and can provide information that is critical to supplement the diagnostic process.

References:

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MASSACHUSSETS ADHD RATING SCALE

ADHD Rating Scale-IV – Home Version

Child's Name: ____ Date: ______________________________

Child's Age: ______ Sex: M F Grade: ____________ Rater's name________________________

Completed by: Mother Father Guardian Grandparent

Circle the number that best describes your child's home behavior over the last 6 months:

		Never or rarely	Sometimes	Often	Very often
1.	Fails to give close attention to details or makes careless mistakes in schoolwork.	0	1	2	3
2.	Fidgets with hands or feet or squirms in seat.	0	1	2	3
3.	Has difficulty sustaining attention in tasks or play activities.	0	1	2	3
4.	Leaves seat in classroom or in other situations in which remaining seated is expected.	0	1	2	3
5.	Does not seem to listen when spoken to directly.	0	1	2	3
6.	Runs about or climbs excessively in situations in which it is inappropriate.	0	1	2	3
7.	Does not follow through on instructions and fails to finish work.	0	1	2	3
8.	Has difficulty playing or engaging in leisure activities quietly.	0	1	2	3
9.	Has difficulty organizing tasks and activities.	0	1	2	3
10.	Is "on the go" or acts as if "driven by a motor."	0	1	2	3
11.	Avoids tasks (e.g., schoolwork, homework) that require sustained mental effort.	0	1	2	3
12.	Talks excessively.	0	1	2	3
13.	Loses things necessary for tasks or activities.	0	1	2	3
14.	Blurts out answers before questions have been completed.	0	1	2	3
15.	Is easily distracted.	0	1	2	3
16.	Has difficulty waiting turn.	0	1	2	3
17.	Is forgetful in daily activities.	0	1	2	3
18.	Interrupts or intrudes on others.	0	1	2	3

Additional comments: