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Re: ADHD Diagnostic Evaluation — Continuity-of-Care Summary

Patient: [Sample Patient] **DOB:** [redacted] **Referring provider:** [To be provided]

To Whom It May Concern,

This letter summarizes the findings of a comprehensive ADHD diagnostic evaluation completed for the above-referenced patient. Following a multi-instrument, DSM-5-TR-anchored assessment, **the patient did not meet full diagnostic criteria for ADHD.** This summary is being provided to support the patient's primary care evaluation and to communicate differential considerations and recommended medical workup — not to request stimulant initiation.

Section 1 — Clinical Presentation

The patient is a 41-year-old male, veterinarian and practice co-owner, who presented for evaluation of longstanding subjective attention and focus difficulties in the context of a high-demand personal and professional life (60+ hour work weeks, co-ownership of a busy clinical practice, raising a young child, and family planning). He reports mental fatigue in the latter half of the workday, procrastination on administrative tasks, and a persistently active mind, with subjective improvement in focus when he has used a family member's non-prescribed Adderall on rare occasions. He denies suicidal ideation, manic symptoms, hallucinations, or psychiatric hospitalization.

Initial screening (ASRS Total 13; Inattentive subscale 8; Hyperactive-Impulsive subscale 5) was suggestive of possible ADHD and prompted further diagnostic evaluation. However, a comprehensive battery of standardized, validated instruments administered as part of this evaluation did not corroborate an ADHD diagnosis (detailed in Section 4). GAD-7 = 5 (mild anxiety); PHQ-9 = 11 (moderate depressive symptom burden), with no endorsement of suicidal ideation. Mental status exam was unremarkable.

Clinical Impression: Based on a comprehensive, multi-instrument evaluation, the patient does not meet full diagnostic criteria for ADHD at this time.

Section 2 — Detailed History of Present Illness

History of Symptoms

Childhood (3–12): Average-to-above-average student who had difficulty focusing across the full school day. Chronic procrastination and a bedroom/home environment that was not neat or organized, with

parents needing to stay on top of homework completion. No documented behavioral referrals, academic failures, or early diagnostic evaluations. **Retrospective standardized assessment of childhood symptom severity (WURS-25) returned a result of "Very Unlikely ADHD" (total 11, normal range),** suggesting clinically significant childhood ADHD symptomatology was not a prominent feature of his developmental history — in contrast to his subjective retrospective impression.

Adolescence/Teen Years (13–18): Competitive athlete (swimming and a regionally-ranked tennis team), suggesting sustained engagement, discipline, and follow-through in structured, high-interest activities. Continued last-minute studying but consistently completed his work. Parents continued to provide structure around academic responsibilities.

Young Adult / College (18–24): Attended a public state university, took a gap year, and later completed a Doctor of Veterinary Medicine (DVM) program. Situational use of a sibling's non-prescribed Adderall for high-stakes exams; denies daily use. Successfully completed a demanding doctoral-level program without documented academic failure.

Present Day: Co-owns and runs a veterinary practice for approximately 8 years, working 60+ clinical hours weekly, while raising a young child and pursuing continuing education. Reports mental fatigue in the latter half of the workday. **Standardized functional impairment testing (WFIRS-S) revealed no domain meeting clinical impairment threshold** (overall mean 0.043; 0/69 items endorsed as "Often" or "Very Often"), and the Executive Skills Questionnaire (ESQ-R) revealed below-average difficulties (15th percentile) with strengths identified across time management, organization, plan management, emotional regulation, and behavioral regulation. Overall, subjective complaints of fatigue and reduced late-day capacity appear more consistent with the demands of an objectively high-intensity lifestyle than with pervasive executive dysfunction meeting Criterion D for ADHD.

Mental Health History

Denies any prior psychiatric diagnosis or treatment; denies prior antidepressant or mood stabilizer use; denies history of trauma, suicide attempt, or psychiatric hospitalization. Mood generally euthymic; attributes elevated PHQ-9 item endorsements (fatigue, concentration difficulty, psychomotor changes) to physical/mental exhaustion related to workload rather than a primary depressive syndrome; specifically denies anhedonia beyond situational fatigue. Denies any manic symptoms — including decreased need for sleep, elevated energy, grandiosity, or risky behavior — even during periods of significant sleep deprivation (e.g., newborn period), a reassuring negative finding for bipolar spectrum illness. The DERS-16 emotional regulation measure indicated very few difficulties with emotion regulation.

Bio-Medical / Physiological History

Past medical history notable only for cholecystectomy (approximately 12 years ago) and tonsillectomy (childhood). Denies cardiac disease, arrhythmia, syncope, hypertension, seizure disorder, liver disease, eating disorder, head injury, or glaucoma. ISI = 2/28 (no clinically significant insomnia); sleeps 7–8 hours nightly with a structured wind-down routine. **Notably, patient has not established care with a primary care physician in approximately 10 years and has not had recent laboratory evaluation.**

Sociological / Environmental History

Raised by both parents in a structured, academically strict household. Two siblings, both diagnosed with ADHD in middle school and treated with stimulants; suspects both parents may have undiagnosed ADHD. Married 5 years, one 2-year-old child, currently trying to grow the family. Caffeine ≈2 cups daily. Alcohol limited to social use on weekends only (2–3 beers Fri or Sat, none during the work week). Denies nicotine, cannabis, or recreational drug use. No trauma history reported.

Section 3 — DSM-5-TR Diagnostic Summary for ADHD (Diagnosis Not Confirmed)

Criterion A (Inattention): Subjectively endorses several inattentive symptoms on interview and the ASRS (difficulty sustaining attention on prolonged tasks, procrastination, losing things, forgetfulness). ASRS Inattentive subscale = 8, Total ASRS = 13, above screening threshold. However, when evaluated against validated normed instruments specifically designed to assess functional and executive impact of these symptoms (ESQ-R, WFIRS-S), his symptom pattern did not reach clinical significance, and multiple domains showed executive strengths rather than deficits.

Criterion A (Hyperactivity/Impulsivity): Subthreshold. Endorses occasional interruption of others and feeling internally "driven," but denies significant motor restlessness. WSR-II hyperactivity/impulsivity domain fell in the mild range (0.89, 22nd percentile).

ASRS Interpretation: ASRS is a screening tool, not a diagnostic instrument, and per CADDRA guidance must be corroborated with collateral, functional impairment measures, and childhood history (CADDRA Guidelines 4.1, Chapter 1, pp. 3–13).

Criterion B (Onset before age 12): Not well corroborated. WURS-25 retrospective childhood symptom measure was in the normal range with a "Very Unlikely ADHD" classification. No academic, behavioral, or disciplinary documentation from childhood available to substantiate pervasive early-onset impairment.

Criterion C (Multiple settings): Symptoms reported at home and work; however, functional impairment ratings in these settings did not reach clinical significance (WFIRS-S Family and Work domain means of 0.1, well below the 1.5 impairment threshold).

Criterion D (Functional impairment): Not substantiated by objective measures. Sustained a demanding doctoral-level education; built and ran a successful independent practice for nearly a decade; denies negative employer feedback; scored in the "Below Average Difficulties" range on executive functioning assessment (15th percentile — fewer difficulties than 85% of comparison adults).

Criterion E (Not better explained by another disorder): Differential considerations include situational fatigue/burnout related to an objectively high-demand lifestyle (60+ hour work weeks, business ownership, new parenthood), mild-moderate depressive symptoms (PHQ-9 = 11), and mild anxiety (GAD-7 = 5), as well as non-psychiatric medical contributors (see below).

Overall Diagnostic Conclusion: Per CADDRA Guidelines 4.1 (Chapter 1: Diagnosis of ADHD, pp. 3–13), ADHD diagnosis requires convergence of self-report, childhood-onset evidence, cross-situational impairment, and functional impact — not screening scores alone. Following comprehensive multi-instrument evaluation, **the patient does not meet full DSM-5-TR diagnostic criteria for ADHD at this time.** No ADHD diagnosis or ICD-10 code is being assigned.

Section 4 — Comorbid Symptom Burden / Screening Summary

• **GAD-7 = 5** (mild anxiety range). Low-grade nervousness, worry, and restlessness "several days," no significant functional impairment.

• **PHQ-9 = 11** (moderate range). Fatigue, concentration difficulty, and psychomotor changes; no anhedonia beyond situational fatigue; item 9 = 0 (no suicidal ideation). Pattern most consistent with fatigue/burnout secondary to lifestyle demands rather than a primary major depressive episode; ongoing monitoring warranted.

• **ASRS = 13** (Inattentive 8, Hyperactive-Impulsive 5). Positive screen, not corroborated by functional/executive measures.

• **WURS-25 = 11**, Normal Range, "Very Unlikely ADHD." Does not support significant childhood ADHD symptomatology.

• **ESQ-R = 10/75**, 15th percentile, "Below Average Difficulties." Strengths in plan management, time management, organization, emotional regulation, and behavioral regulation.

• **WFIRS-S = 3/69 items, mean 0.043.** No domain (Family, Work, School, Life Skills, Self-Concept, Social, Risk) met the clinical impairment threshold (mean ≥1.5).

• **DERS-16 = 17, "Very Low" difficulties**, lower than approximately 100% of clinical comparison sample. Does not support significant emotional dysregulation.

• **WSR-II:** Attention "Mild" (33rd %ile); Hyperactivity/Impulsivity "Mild" (22nd %ile); Anxiety, Depression, Mood Regulation, Substance Use, PTSD, Psychosis, Autism Spectrum, Eating, Conduct, Oppositional, and Suicide domains all scored 0 / non-significant.

• **ISI = 2/28**, no clinically significant insomnia; no signs suggestive of sleep apnea (denies snoring, corroborated by spouse).

No indication of substance use disorder. No bipolar spectrum symptoms endorsed. No safety concerns identified across any instrument.

Section 5 — Assessment

1. Attention/concentration difficulties, **insufficient to meet ADHD diagnostic criteria at this time** (R41.840) — differential includes situational fatigue/burnout, possible mild-moderate mood/anxiety symptoms, and non-psychiatric medical contributors.

2. Unspecified depressive symptoms, moderate by PHQ-9, without SI (F32.9) — for evaluation and monitoring by appropriate treating provider; not treated by this practice.

3. Mild anxiety symptoms by GAD-7 (F41.9) — for evaluation and monitoring by appropriate treating provider; not treated by this practice.

4. Lack of established primary care / overdue preventive health maintenance (Z76.89).

5. Non-prescribed stimulant use, situational, remote history (Z79.899 / historical) — no active substance use disorder identified.

Section 6 — Treatment Plan

ADHD diagnosis was not confirmed on comprehensive evaluation; therefore, this practice is not recommending initiation of stimulant or non-stimulant ADHD pharmacotherapy at this time. Prescribing a stimulant in the absence of a confirmed diagnosis would not be consistent with CADDRA Guidelines 4.1 (Chapter 1, pp. 3–13), which require corroborated evidence of childhood onset, cross-situational impairment, and functional impact prior to initiating stimulant treatment — particularly given this patient's history of non-prescribed stimulant use.

Recommendations for the Receiving PCP

- Complete a full physical examination and baseline laboratory workup: TSH/free T4, CBC with iron studies/ferritin, Vitamin D 25-OH, fasting glucose/HbA1c, and consideration of morning total testosterone given fatigue complaints in an adult male — to rule out correctable medical contributors to reported attention / concentration difficulty and fatigue.
- Baseline vital signs (BP, HR, weight/BMI) obtained and monitored regularly as part of routine primary care, given the absence of PCP care for approximately 10 years.
- Given moderate PHQ-9 (11) and mild GAD-7 (5), evaluate and follow for depressive and anxiety symptoms; this practice does not manage or prescribe medication for mood or anxiety disorders, and no specific antidepressant/anxiolytic agent is recommended here.
- Should laboratory workup be unremarkable and symptoms of inattention persist or worsen despite addressing lifestyle / workload factors, re-evaluation for ADHD with additional collateral information (e.g., structured childhood report, workplace performance review) could be considered — with this practice or a local specialist.
- If, following further workup, an ADHD diagnosis is subsequently established, first-line treatment consideration would reasonably begin with a long-acting stimulant formulation per CADDRA first-line classification, with routine cardiovascular and psychiatric monitoring. This is not being recommended at the present time given the current diagnostic conclusion.

Diagnostic Considerations & Limitations

This evaluation was based on clinical interview, self-report screening instruments, and multiple standardized validated questionnaires completed by the patient. No formal neuropsychological testing, collateral informant report (e.g., spouse-completed rating scale), or direct school records review were available. The patient's self-reported ASRS screen was positive, but this was not corroborated by objective functional impairment or executive function testing, retrospective childhood symptom measures, or emotional regulation measures, all of which fell within normal limits. This discrepancy was weighed heavily in the diagnostic conclusion, consistent with CADDRA's emphasis on multi-source, functionally-anchored diagnosis rather than screening scores in isolation.

Telemedicine Disclosure

This evaluation was conducted via telemedicine. Applicable state regulations in the patient's jurisdiction restrict the prescribing of controlled stimulant medications through telemedicine-only practices. This consultation note is intended to support continuity of care with the patient's local, in-person primary care physician.

Scope of Care

This practice's scope is limited to ADHD-focused evaluation and treatment. Comorbid depressive and anxiety symptoms identified in this evaluation should be addressed by the patient's primary care physician or an appropriate mental health provider; no specific psychotropic medication for mood or anxiety disorders is recommended by this practice.

Sincerely,

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Board-certified, Public Health and Preventive Medicine

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