ADHD — Screening, Differentials & Referral

Validated screeners, mimics to exclude & when to refer

CLINICAL PATHWAY

Screen, don't diagnose, in general practice. A positive screen is not a diagnosis — exclude medical mimics first, then refer to psychiatry (adult) or paediatrics (child) for a formal DSM-5-TR assessment.

VALIDATED SCREENING TOOLS

- **ASRS-5 (WHO):** 6-item self-report screener, sensitivity 91.4%, specificity 96% — use Part A (≥4 ticked = probable ADHD); quick, free, validated for primary care
- **CAARS-2:** Conners Adult ADHD Rating Scales (66-item) — inattention, hyperactivity, impulsivity and emotional dysregulation subscales; used by specialists for fuller assessment
- **Collateral history:** family, partner or teacher report of childhood symptoms — old school reports are invaluable; look for comments on attention, incomplete work, disruptiveness

DIFFERENTIALS TO EXCLUDE FIRST

- **Sleep disorders:** OSA, insomnia — screen snoring, witnessed apnoeas, daytime sleepiness, Epworth score
- **Thyroid dysfunction:** hypothyroidism mimics inattention/fatigue, hyperthyroidism mimics hyperactivity — check TSH first
- **Anxiety/depression:** both cause poor concentration and restlessness — key question: were symptoms present before age 12, before the mood episode?
- **Substance use:** cannabis mimics inattention/disorganisation and persists for weeks after stopping — baseline urine drug screen is reasonable
- **Bipolar disorder:** distinguish manic hyperactivity (elevated mood, grandiosity, reduced sleep need, risky behaviour) from ADHD restlessness — screen with MDQ if in doubt

WHEN TO REFER

- ADHD suspected with clear functional impairment across home, school or work — don't attempt a diagnosis in general practice without specialist support
- Significant comorbid psychiatric features — depression, anxiety disorder, bipolar disorder or autism spectrum disorder need specialist co-assessment
- Adults with childhood school reports, parental accounts, or sibling/family corroboration of early-onset symptoms — this evidence matters for Criterion B and for PBS subsidy eligibility
- Suspected substance use disorder — diagnosis alongside active SUD needs specialist oversight and risk-benefit assessment

GP SCOPE OF PRACTICE — VICTORIA

Current as at June 2026: GPs generally need a Schedule 8 treatment permit (via SafeScript) to continue stimulants, issued only with evidence of specialist diagnosis and periodic specialist review; a PBS authority script does not remove this requirement. A Victorian Government reform is underway — an initial 150 GPs begin RACGP training from September 2026 to diagnose and treat ADHD independently (adults and children 6+); the Victorian Virtual Emergency Department offers a safety-net prescription service for existing diagnoses from September 2026. Confirm current status at health.vic.gov.au before relying on this.

■ SAFETY

- Don't refer during an active mood episode — treat depression or mania first and reassess ADHD once stable for 4–8 weeks; many apparent ADHD symptoms resolve fully
- Don't refer during active intoxication or within 4 weeks of heavy cannabis/stimulant use — these directly mimic core ADHD symptoms and will invalidate the assessment
- Exclude OSA, hypothyroidism and significant hearing impairment before referring — each can mimic inattention on its own

■ RED FLAGS / REFER

- Psychotic symptoms present → refer for psychosis management, not ADHD assessment
- Significant trauma/PTSD features → address separately before pursuing an ADHD referral
- Diagnostic criteria appear met and mimics excluded → refer to psychiatry (adult) or paediatrics (child) for formal assessment; screen comorbidities in parallel (MH-01C)