**EARLY CHILDHOOD ELIGIBILITY PHYSICIAN’S STATEMENT**

Oregon Administrative Rules require this verification by a MD, DO, NP, PA, ND, or licensed clinical psychologist.

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| --- | --- |
| Patient Name:       | Clinic Name:       |
| DOB:       | Physician Name:       |

The above child has applied for Intellectual/Developmental Disabilities Services. A statement by a licensed medical practitioner affirming a developmental disability (neurological condition originating in the brain) may be used to determine eligibility for **children under age 7** when a standardized early childhood assessment has not been completed within the past year.

1. Please help us verify if your patient has the following condition(s), syndrome, or diagnoses:

[ ] Down Syndrome [ ] Global Developmental Delay [ ] Epilepsy [ ] Angelman Syndrome

[ ] Autism Spectrum [ ] Cerebral Palsy [ ] Fragile X [ ] Fetal Alcohol/Drug

[ ] Kleinfelter’s [ ] PKU [ ] Prader-Willi [ ] Rett’s Syndrome

[ ] TBI/ABI [ ] Tourette’s [ ] Williams

[ ] Other conditions as listed below: i.e., Mental Health, Physical, other DD conditions:

1. **Co-occurring diagnoses cases:** The I/DD condition [ ]  DOES [ ]  DOES NOT directly cause adaptive behavior delays/impairment.
2. Please note which areas of adaptive behavior are significantly impaired, or likely to be significantly impaired. **PLEASE CHECK ALL THAT APPLY:**

[ ]  Adaptive OR Self-Care OR Self-Direction ­­[ ]  Expressive AND Receptive Language OR Communication

[ ]  Learning OR cognition [ ]  Gross AND fine motor [ ]  Social

1. Do you expect impairment from I/DD conditions to last indefinitely? [ ]  Yes [ ]  No

1. I am unable to provide information about the diagnosis and adaptive functioning for the following reason:

**Practitioner’s Signature & Title** **Date**

**Printed Name & Title**

**PLEASE CONTACT WITH QUESTIONS, or RETURN by FAX or EMAIL, TO:**

**Attn:        Email:** **Phone:**

**Fax:**