**EARLY CHILDHOOD ELIGIBILITY PHYSICIAN’S STATEMENT**

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

|  |  |
| --- | --- |
| 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:**       