**I/DD SCHOOL-AGE OR ADULT ELIGIBILITY PHYSICIAN’S STATEMENT**

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

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

The above individual has applied for Intellectual/Developmental Disabilities Services. A statement by a “Qualified Professional” as described in OAR (above) affirming a developmental disability may be used to determine eligibility when a standardized adaptive assessment has been completed indicating adaptive behavior impairment.

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. **COMPLETE THIS SECTION ONLY IF CO-OCCURRING CONDITIONS EXIST. Co-occurring Conditions Clinical Opinion:**

Does I/DD directly cause adaptive behavior impairment, regardless of co-occurring mental/emotional disorders, personality disorders, motor impairment (not C.P.), sensory impairment, learning disabilities, ADHD or substance abuse disorders?

**I/DD:**  DOES  DOES NOT directly cause adaptive behavior impairment.

1. Is the Intellectual/Developmental Disability and impairment reasonably expected to last indefinitely?  Yes  No
2. I am unable to provide information about diagnoses/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:**       