**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:**