

Medical Statement (Children under 6 years old)

Per Oregon Administrative Rules, a statement by a MD, DO, NP, PA, ND or Licensed Clinical Psychologist (Ph.D or Psy.D) may be used to determine eligibility for our services. For this age group, a medical statement indicating "global developmental delay" or another neurological condition may be used in lieu of standardized testing when testing has not been conducted. All children we find to fit our eligibility criteria are considered to be provisionally eligible. If you would please complete this form at your earliest convenience.

TO: \_\_\_\_\_

RE: \_\_\_\_\_ DOB: \_\_\_\_\_

Please list diagnosed medical conditions (s) and/or syndrome(s)

\_\_\_\_\_ Date or age of onset: \_\_\_\_\_

\_\_\_\_\_ Date or age of onset: \_\_\_\_\_

\_\_\_\_\_ Date or age of onset: \_\_\_\_\_

Which condition(s) is the primary reason for delays?

Does this condition originate in and directly affect the brain?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Is this condition expected to continue indefinitely?

Please check all areas of functioning this condition causes or is likely to cause impairment.

- |   |  |
|---|--|
| <input type="checkbox"/> Adaptive, Self-Care or Self-Direction              | <input type="checkbox"/> Learning or Cognition |
| <input type="checkbox"/> Social   | <input type="checkbox"/> Gross and fine motor  |
| <input type="checkbox"/> Receptive and Expressive Language or Communication |  |
| <input type="checkbox"/> Other: _____                                       |  |

(Please Print) Practitioner Name & Title

Date

Signature *Must be Signed by* MD, DO, NP, PA, ND, Licensed Clinical Psychologist (PhD or PsyD)

Please return to: ddintakerecords@multco.us (preferred method)  
Fax: 503-988-3059 (2<sup>nd</sup> preferred method)  
Multnomah County I/DD 209 SW 4<sup>th</sup> Ave Portland, OR 97204

Questions? 503-988-6356