

## Childhood Medical Disability Report

<b>Child's Name:</b> (Last, First, Middle)	<b>Case Number:</b>	<b>Date of Birth:</b>
<b>Agency:</b>  State Disability Review Unit 8th Floor OCP State of New York Department of Health Albany, NY 12237	<b>Client ID Number:</b>	<b>Disability ID Number:</b>
	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
	<b>Worker Name:</b>	
	<b>Phone Number:</b> 1-866-330-0591	<b>Date:</b>

1. Dates of Treatment – First:	Last:	Frequency:	
2. Diagnosis(es):			
3. Please give a history, including date(s) of diagnosis and earliest symptoms, etiology of impairment, initial findings on physical examination, treatment (including any surgical procedures) and subsequent course.			
4. Please give findings on last examination. Date of last examination _____ .			
Height without shoes:	Weight:	B/P:	Pulse:
Please give pertinent physical findings:			

5. Please note if the child's function/ behavior is age-appropriate; if not, note actual age level and describe basis for your observation.

Fine/Gross Motor Skills	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ Years    ____ Months
Sensory Abilities	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ Years    ____ Months
Communication Skills	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ Years    ____ Months
Cognitive Skills	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ Years    ____ Months
Social-/Emotional Skills	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ Years    ____ Months

<b>Provider Signature:</b>	<b>Print Provider Name:</b>
<b>Office Address:</b>	<b>Specialty, if any:</b>
	<b>Telephone Number:</b>
	<b>Date Signed:</b>