

Childhood Medical Disability Report

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

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	☐ Yes ☐ No	____ Years ____ Months
Sensory Abilities	☐ Yes ☐ No	____ Years ____ Months
Communication Skills	☐ Yes ☐ No	____ Years ____ Months
Cognitive Skills	☐ Yes ☐ No	____ Years ____ Months
Social-/Emotional Skills	☐ Yes ☐ No	____ Years ____ Months

Provider Signature:	Print Provider Name:
Office Address:	Specialty, if any:
	Telephone Number:
	Date Signed: