Ohio Department of Developmental Disabilities

Diagnosis Verification (Ages birth through age 9)

Individual: _____ DOB: _____

Please have the appropriate clinician complete the below information.

Does the child have at least one of the following:

1. A substantial developmental delay?
   ☐ Yes ☐ No

   In what area(s) do delay(s) exist? _____

_____

Instrument: _____ Date administered: _____

OR

2. A diagnosed congenital or acquired condition, other than an impairment caused solely by a mental illness?
   ☐ Yes ☐ No

List the diagnoses: _____

Is the above-mentioned condition and/or delay likely to result in substantial functional limitation in any of the following major life areas if the individual does not receive the appropriate services/supports?

Self-care (bathing, grooming, eating, toileting, etc.)	☐ Yes	☐ No
Expressive/receptive language	☐ Yes	☐ No
Learning/cognition	☐ Yes	☐ No
Mobility (locomotion, positioning, transfers)	☐ Yes	☐ No
Self-direction (decision-making, judgment)	☐ Yes	☐ No
Independent living (household tasks)	☐ Yes	☐ No
Economic proficiency (money management)	☐ Yes	☐ No

_____ _____

Name of Physician or Licensed Psychologist License number

_____ _____

Signature of Physician or Licensed Psychologist Date

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