NEW YORK STATE DEPARTMENT OF HEALTH
State Disability Review Unit

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: