Patient Name:_____
Date of Birth:_____
Doctor's Name:_____
Clinic Name:_____

Questionnaire for Doctors of Disabled Students

Please describe the challenges that your patient experiences with meeting daily needs, due to his or her disabilities. If you need more room, please use additional paper. Your time is greatly appreciated. Thank you.

Please convey how dependent your patient is due to deficits in:

- Self-Care Skills (bathing, grooming, dressing, eating, meal preparation),_____

- Severe Behavior Problems (if any, and their frequency. i.e. tantrums, aggression, smearing feces, etc.),_____

- Medical Conditions (i.e. ADHD, seizures). Describe any medical conditions that may or may not require daily-individualized attention from health care staff and treatments (i.e. IVIg, or daily injections).

Please describe your patient's ability in the following areas:

Adaptive behaviors - (i.e. communication, some or no expressive or receptive language):

Learning - (particularly if IQ 75 or lower):

Mobility Skills - (even if ambulatory - if your patient needs assistance or training to increase capacity for moving about):

Capacity for Independent Living - (i.e. is she completely dependent for all household activities): _____

Self-Direction - (child demonstrates daily, weekly or monthly misbehaviors requiring individualized programming, i.e. home program or special school), and whether your patient is dependent on others for management of their personal affairs within their community:

Notes - If you have any other information to share about your patient and his or her disability, please do so here:

_____
Doctor's Signature

_____
Date