



Seneca County Opportunity Center

SENECA COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

Diagnosis Verification (Ages 3-5)

Individual: _____ DOB: _____

[Please have the appropriate clinician complete the information below]

1. Does the child have at least TWO areas of developmental delay? Yes No

In which areas do delays exist?: _____

*Please indicate the instruments used to determine the presence of these delays and the date administered:

Instrument: _____ Result: _____ Date: _____

2. Does the child have a condition diagnosed at birth, or acquired later (other than impairment caused only by mental illness) that results in developmental delays? Yes No

Please list the child's diagnosis: _____

3. Is this condition likely to continue indefinitely? Yes No

4. Is the child's condition both severe and chronic? Yes No

5. Does the condition cause the child to need a combination and sequence of special, interdisciplinary, or other type of care, treatment, or provision of services for an extended period of time that is individually planned and coordinated? Yes No

Clinician name: _____ License number: _____

Clinician signature: _____ Date: _____

Please Return Completed Forms to:

Seneca County Board of DD
Attn: Lexie Fretz, Intake Coordinator
780 E. CR 20
Tiffin, OH 44883

lefretz@senecadd.org
Phone: 419-447-7521
ext. 1119
Fax: 419-448-5294