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| CSO-1326A (10-16) |
| ARIZONA DEPARTMENT OF CHILD SAFETY |
| **PROFESSIONAL DOCUMENTATION FOR POST-ADOPTIVE CONDITIONS** |

This form is to be completed by a medical professional, psychiatrist, psychologist or other professional credentialed to make the diagnosis. A signed letter or medical record may be attached to this form.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CHILD’S NAME: *(Last, First, M.I)* | | BIRTH DATE: | | | | ADOPTION DATE: | | | |
| **DIAGNOSIS** | **DIAGNOSTIC CODE** | | **SEVERITY** | | | | | | |
|  |  | | 1 = Mild, 5 = Extremely Severe | | | | | | |
|  |  | | 1 | | 2 | | 3 | 4 | 5 |
|  |  | | 1 | | 2 | | 3 | 4 | 5 |
|  |  | | 1 | | 2 | | 3 | 4 | 5 |
|  |  | | 1 | | 2 | | 3 | 4 | 5 |
|  |  | | 1 | | 2 | | 3 | 4 | 5 |
| Was each of the conditions listed above pre-existing at the time of the adoption? | | | | | | | | | |
| YES | | NO | | | | | | | |
| Was each of the conditions listed above undiagnosed at the time of the adoption to the best of your knowledge? | | | | | | | | | |
| YES | | NO | | | | | | | |
| Treatment Plan *(Include type of treatment and/or equipment necessary, prognosis, cost estimates):* | | | | | | | | | |
| **I am making this statement based on the best information available to me at this time.** | | | | | | | | | |
| PROFESSIONAL’S SIGNATURE: | | | | DATE: | | | | | |
| PROFESSIONAL’S PRINTED NAME: | | | | | | | | | |
| CREDITNALS/DEGREE: | | | | | | | | | |
| CURRENT AZ LICENSURE/CERTIFICATION (If Applicable): | | | | | | | | | |
| ADDRESS: | | | | PHONE: | | | | | |

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