



GOVERNMENT
of JAMAICA
MINISTRY OF LABOUR
& SOCIAL SECURITY



Jamaica Council for
Persons with Disabilities
EDUCATING • ADVOCATING • EMPOWERING



Photo

Jamaica Council for Persons with Disabilities Medical Report-ADULT

JCPD ADULT MEDICAL REPORT
SECTION: **Kindly complete this Page**

Kindly complete the first page of this form for **all** clients then, complete **ONLY** the relevant section on the other pages based on the disability identified. For guidelines on the criteria for identifying each disability please see attached guidelines. **Form is to be completed in BLOCK letters**

Title: Mr. Miss. Mrs. Dr. Professor

Name _____ Male Female
Last Name First Name Middle Name(s)

Home Address: _____

Usual or Previous occupation _____ **TRN #** _____

Current Occupation (if any) _____

Type of Disability (ies): _____

Nature of Disability:

Temporary Permanent Progressive Improving Static

Other (*specify*) _____

Degree of disablement:

Minimal Mild Moderate Severe Profound

Treatment (if any) _____

Treatment, assistive devices / prosthetic appliances or aids (specify):

Date of Disablement: _____ / _____ / _____
Yr. Mth Day

Medical diagnosis (Cause):

Name of person completing form: _____

Address: _____

Contact Number(s): _____ / _____ / _____
Home Work Mobile

To be completed if client has Physical Disabilities

Functional Assessment –to be completed by General Practitioner /Orthopedic Specialist

Indicate ability, in words, e.g. “moderate,” “weak” “poor” “nil” and percentages

Use of Upper Limb

Shoulder		Arms		Hands		FINGERS		Reaching Overhead	
LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT

Reaching Away from Body		Use Limb	
LEFT	RIGHT	LEFT	RIGHT

Use of Lower Limbs

Walking (Distance/Frequency)		Standing Tolerance (Time)		Sitting Tolerance (Time)		Balance		Kneeling	
LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT

Not able to use Limb	
LEFT	RIGHT

Ability to

Stoop/Bend	Push/Pull (kgs: distance)	Lift/Carry (max.kgs:distance)	Repetitive Lift/Carry (max.kgs:distance)	Climb	Travel to work	Sit	Stand

Description of work:

Physical Effort

Much	Little

Description of Work: Work Tolerance

Full-time	Part-time	Shift Work

Specific Limitations/Restrictions : _____

Summary\Overview: _____

Name of Doctor: _____

Signature of Doctor: _____

Date: _____ / _____ / _____
Yr. Mth Day



Complete this section if person has an Intellectual or Developmental Disability

Intelligence/Cognitive Assessment - to be completed by Registered Psychologist (e.g. Psycho-Educational or Clinical)

Intelligence/Cognitive Functioning (*Level of Intellectual Function & type of Support need*)

Mild: Intermittent Moderate Limited Profound; and Pervasive

Age at Diagnosis: _____ Date of Initial diagnosis: _____ / _____ / _____
Yr. Mth Day

Name of Clinician/Doctor: _____

Address: _____

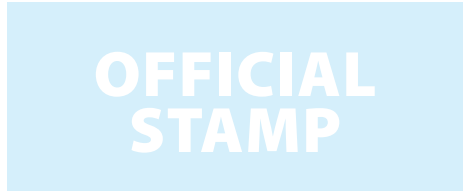
Telephone Contact: _____ Date of last psychological evaluation: _____ / _____ / _____
Yr. Mth Day

Name & Signature of Clinician/Doctor: _____

Address: _____

Telephone Contact: _____ Email: _____

Date of Completion: _____ / _____ / _____
Yr. Mth Day



Psychiatric Evaluation (Ages 18 and over) - To be completed by Psychiatrist

To be completed if client has psychiatric disorder or mental illness

Name: _____
Last Name First Name Middle Name(S)

Sex: Male Female Date of Birth: _____ / _____ / _____ Age: _____
Yr. Mth Day

Marital Status

Single Common-Law Married Separated Widowed Divorced

Occupation: _____

Diagnosis (es): _____

Age at which diagnosis was first made: _____

Progress of Illness

Improving Improved Stable Deteriorating Fluctuating Other State

Prescribed treatment: Medication/ Psychotherapy/Occupational Therapy/

Other _____ (State)

Level of compliance with treatment: Very Good/ Good/ Fair/ Poor

(Explain) _____

Level of Functioning:

Normal Mildly Impaired Moderately Impaired Severely Impaired

Level of social and family support:

Very Good Good Fair Poor

(Explain) _____

Lives independently: Yes No

If no, explain with whom: _____

Is disorder like to be? Short term Permanent

Other (Explain) _____

Recommended Time for Review

Additional Comments:

Name of Psychiatrist: _____

Signature of Psychiatrist: _____

Date of Completion: _____ / _____ / _____
Yr. Mth Day



To be completed if client has visual or hearing disabilities

Hearing/Visual Assessment –to be completed by Ophthalmologist or Audiologist

Hearing: Left Right Both

Vision: Left Right Both

(Explain) _____

Level of Functioning:

Normal Mildly Impaired Moderately Impaired Severely Impaired

Level of social and family support:

Very Good Good Fair Poor

Cause of Disability/Etiology: _____

Degree of hearing loss: db=decibels

- Mild** Sounds softer than 25 dB to 40 dB are not detected
- Moderate** Sound softer than 40 dB to 65 dB are not detected
- Severe** Sound softer than 65 dB to 90 dB are not detected
- Profound** Sounds softer than 90 dB are not detected

Summary

MAIN MEDICAL PROBLEM(S) *In order of priority* _____

RECOMMENDATION(S) *Who will implement them* _____

CRITERIA for IMPROVEMENT: _____

NAME AND SIGNATURE OF DOCTOR

____/____/____
Date: Yr. Mth Day

SIGNATURE OF APPLICANT

____/____/____
Date: Yr. Mth Day

