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

Jamaica Council for Persons with Disabilities

Medical Report-ADULT

JCPD ADULT MEDICAL REPORT
SECTION: **A**

A

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

OFFICIAL STAMP

Jamaica Council for Persons with Disabilities

Medical Report-ADULT

JCPD ADULT MEDICAL REPORT
SECTION: **B**

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

OFFICIAL STAMP

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)

Medical Report-ADULT

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

(*Explain*) _____

_____

_____

_____

_____

Level of Functioning:
Normal ☐ Mildly Improved ☐ 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

OFFICIAL STAMP

Medical Report-ADULT

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 Improved ☐ 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

OFFICIAL STAMP