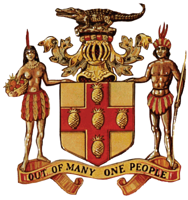


GOVERNMENT *of* JAMAICA
MINISTRY OF LABOUR & SOCIAL SECURITY

Jamaica Council for Persons with Disabilities
EDUCATING • ADVOCATING • EMPOWERING

Jamaica Council for Persons with Disabilities

Medical Report-ADULT

JCPD ADULT MEDICAL FORM
Functional Assessment

*Kindly complete this form for **all** clients based on the disability identified. For guidelines on the criteria for identifying the 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: ____

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 / Diagnosis : __________/__________/__________ **Age of First Diagnosis** : __________
Yr. Mth Day

Medical diagnosis (*Cause*):

____

____

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 : ____

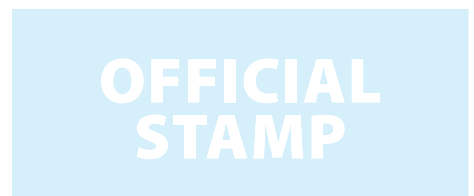
____

Summary\Overview: ____

____

____ ______/______/______

SIGNATURE OF APPLICANT **Date:** Yr. Mth Day



Name of GP/Orthopedic Specialist: ______________________________

Signature of GP/Orthopedic Specialist: ______________________________

Address/Place of Practice: ______________________________

Contact Number: ______________________________ **Email:** ______________________________

Date of Completion: ______/______/______

Yr. Mth Day