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 FORM
Hearing/Visual 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 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 ☐

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: _____

_____

_____

_____ _____/_____/_____

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

Name of Audiologist/Ophthalmologist: _____

OFFICIAL STAMP

Signature of Audiologist/Ophthalmologist: _____

Address/Place of Practice: _____

Contact Number: _____ **Email**: _____

Date of Completion: _____/_____/_____

Yr. Mth Day