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

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**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

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## 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

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# 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

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