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
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: _____

OFFICIAL STAMP

Address/Place of Practice: _____

Contact Number: _____ **Email**: _____

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