



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 : \_\_\_\_\_

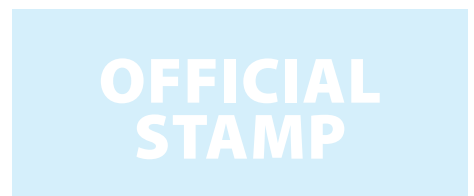
Summary\Overview: \_\_\_\_\_

\_\_\_\_\_  
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