



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 Impaired 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* _____

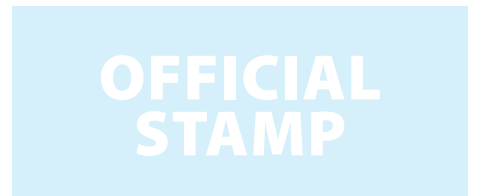
CRITERIA for IMPROVEMENT: _____

SIGNATURE OF APPLICANT

_____/_____/_____
Date: Yr. Mth Day

Name of Audiologist/Ophthalmologist: _____

Signature of Audiologist/Ophthalmologist: _____



Address/Place of Practice: _____

Contact Number: _____ **Email:** _____

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