



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
**Intelligence/Cognitive
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):

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

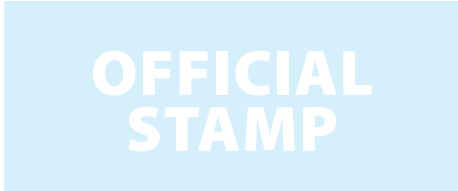
Date of last psychological evaluation: ____ / ____ / ____
Yr. Mth Day

SIGNATURE OF APPLICANT

____ / ____ / ____
Date: Yr. Mth Day

Name of Clinician: _____

Signature of Clinician: _____



Address/Place of Practice: _____

Contact Number: _____ **Email:** _____

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