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 for Children

JCPD CHILDREN MEDICAL FORM
Psychiatric Evaluation for Children

*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***

Name _____ Male ☐ Female ☐
Last Name First Name Middle Name(s)

Age: _____ **Date of Birth**: _____/_____/_____ **Nationality**:_____
Yr. Mth Day

Home Address: _____

Email Address: _____

Contact Number(s): _____/_____
Home Mobile

Name of Parent/Guardian: _____ **Occupation** _____

Type of Disability: _____

Nature of Disability:
Temporary ☐ Permanent ☐ Progressive ☐ Improving ☐ Static ☐

Other (*specify*) _____

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

Treatment, assistive devices / prosthetic appliances required (*specify*):

_____

_____

Psychiatric Evaluation for Children *(less than 18 years) - To be completed by Psychiatrist*

To be completed for children with mental disorders or mental illness

Name: _____
Last Name First Name Middle Name(s)

Sex: Male ☐ Female ☐ **Date of Birth**: _____/_____/_____ **Age**:_____
Yr. Mth Day

Name of Parent/Guardian: _____ **Relationship**: _____

Address of child: _____

Is child attending school?: Yes ☐ No ☐ **If so, current grade**: _____

Diagnosis (es): _____

Age at which diagnosis was first made: _____

Level of functioning at school
Improving ☐ Improved Stable ☐ Deteriorating ☐ Fluctuating Other (*State*): _____

Level of functioning at home
Improving ☐ Improved Stable ☐ Deteriorating ☐ Fluctuating ☐

Other (*State*): _____

Level of impairment:
Mild ☐ Moderate ☐ Severe ☐

Prescribed treatment: Medication/ Psychotherapy/Occupational Therapy/

Other _____ (State)

Level of compliance with treatment: Very Good/ Good/ Fair/ Poor

(*Explain*) _____

Progress
Improving ☐ Improved Stable ☐ Deteriorating ☐ Fluctuating ☐

Likely Progress
Expected to improve ☐ Deterioration ☐ Remain same ☐ Other (*State*): _____

Additional Comments: _____

_____ _____/_____/_____
SIGNATURE OF PARENT/CAREGIVER **Date:** Yr. Mth Day

Name of Psychiatrist: _____

Signature of Psychiatrist: _____

OFFICIAL STAMP

Address/Place of Practice: _____

Contact Number: _____ **Email**: _____

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