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
Psychiatric Evaluation

*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*):

_____

_____

Psychiatric Evaluation *(Ages 18 and over) - To be completed by Psychiatrist*
To be completed if client has psychiatric disorder or mental illness

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

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

Marital Status
Single ☐ Common-Law ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐

Occupation: _____

Progress of Illness
Improving ☐ Improved Stable ☐ Deteriorating ☐ Fluctuating ☐ Other State ☐

Prescribed treatment: Medication/ Psychotherapy/Occupational Therapy/

Other _____ (State)

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

(*Explain*) _____

Level of Functioning:
Normal ☐ Mildly Improved ☐ Moderately Impaired ☐ Severely Impaired ☐

Level of social and family support:
Very Good ☐ Good ☐ Fair ☐ Poor ☐ (*Explain*) _____

Lives independently: Yes ☐ No ☐

If no, explain with whom: _____

Is disorder like to be? Short term ☐ Permanent ☐

Other (*Explain*) _____

Recommended Time for Review:

_____

_____ _____/_____/_____
SIGNATURE OF APPLICANT **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