Confidential Medical & Functional Capacity Report

CONFIRMING DISABILITY FOR ELIGIBILITY FOR WAGE SUBSIDY SCHEME
(WHEN THE APPLICANT IS NOT ON A QUALIFYING DEASP DISABILITY PAYMENT AND PROFESSIONAL MEDICAL CONFIRMATION OF DISABILITY IS REQUIRED IN ORDER TO PROCESS THE APPLICATION.)

Name: ________________________________ Date of Birth: ____________________

Address: ____

PPS No: ______________________________ My patient since: ________________

Medical Details

Does this person have a **disability*** or a long-term **medical condition/s?**

Yes ☐ No ☐

*A physical, learning or mental health difficulty, which has a substantial and adverse effect on the person's ability to carry out day to day activities. (In this context, substantial means not minor and long-term means expected to last at least a year). The definition of disability is as contained in the Disability Act, 2005.

If yes, please describe: ____

____

When did the condition(s) that led to the reduction of work capacity start? _________

____

How long do you expect the condition(s) to continue? ________________________

____

Please give details of any ongoing and/or anticipated medical/surgical interventions:

____

____

Does your patient take medication?

Yes ☐ No ☐

What side effects (if any) does your patient experience? ______________________

____

Functional Assessment

Mental Health				
	Normal	Mildly Impaired	Moderately Impaired	Severely Impaired
Coping with ADL				
Completion of tasks				
Coping with change/pressure				
Interaction with others				

Physical Health (Impairment Scale)					
	Normal	Mild	Moderate	Severe	Profound
Hearing (R/L)					
Vision (R/L)					
Dexterity (R/L)					
Shoulders					
Arms					
Hands					
Fingers					
Mobility					
Walking					
Static standing					
Dynamic standing					
Sitting					
Ability to use public transport					
Agility					
Balance					
Climbing stairs					
Stooping/bending					
Strength					
Push and pull					
Lift and carry					

Comments:

____

____

Occupational Details

Is this person fit to work at least 21 hours per week?

Yes ☐ No ☐

Proposed employment: ____

Do you consider that this person's disability or medical condition(s) is causing or could cause him/her to have a shortfall in productivity in the proposed employment in comparison to a colleague without a disability or medical condition(s)?

Yes ☐ No ☐

Please give any additional information that may assist this application:

In my opinion, this person has ____

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____

Name of Doctor/Specialist: ____

Signature of Doctor/Specialist: ____

IMC No: ________________________________

Address: ________________________________

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____

Date: __________________________________

Please return the completed form to your patient.

Thank you for your assistance.