Ontario Common Assessment of Need (OCAN)

Community Mental Health Common Assessment Project

Full OCAN 3.0

April 2018

v0.2

CCIM Community Care Information Management
ACCESS TO INFORMATION

OCAN Consumer Self-Assessment

Have your own voice heard

This organization uses OCAN to understand your needs. We invite you to complete this brief self-assessment that captures areas of your life where you need support and where things are going well. Completing the self-assessment helps us to focus on services that support the needs you have identified.

You decide what you would like to share

The self-assessment is optional. When completing the self-assessment, you can chose not to respond to questions you're not comfortable with. Your decision on whether or not to complete all or parts of the self-assessment will not change the services you're accessing.

Why we encourage you to complete the Self-Assessment:

- Gives you a voice by capturing your perspective
- Services and supports are directed to areas that are most important to you
- You only need to respond to questions that you feel comfortable discussing

Name:	
Date of Birth (YYYY-MM-DD):	
Start Date (YYYY-MM-DD):	**Completion Date (YYYY-MM-DD):**

INSTRUCTIONS:

The self-assessment covers 24 life domains or areas of your life. The following steps will help guide you to complete the assessment. Let your worker know if you need help.

1. Read the first life domain in the assessment e.g. (Accommodation) and consider your needs in that area of your life.
2. The questions just beneath the domain are there to help you think about whether this is a problem (area of need) and whether you're getting the help you need.
3. Check off one of the four boxes identifying your need rating in that domain using the definitions below. **Notice that one of the boxes you can tick off is "*I don't want to answer*". Feel free to tick this box off for any domains you don't feel comfortable answering.**
4. You are encouraged to provide comments so your worker can better understand your situation.
5. Following the 24 domains, there are 5 questions. Responding to these questions will capture what's important to you, your strengths and your recovery goals.

No Need = this area is not a serious problem for me at all
Met Need = this area is not a serious problem for me because of the help I am given
Unmet Need = this area remains a serious problem for me despite any help I am given
I Don't Want to Answer = I prefer not to respond

		No Need	Met Need	Unmet Need	I Don't Want to Answer
1.	**Accommodation**	☐	☐	☐	☐
	Are you happy with the place you live in or has it been a problem (an area of need)? Are you getting the help you need? **Comments**				
2.	**Food**	☐	☐	☐	☐
	Has getting food that suits your dietary needs been a problem (an area of need)? Are you getting the help you need? **Comments**				
3.	**Looking After the Home**	☐	☐	☐	☐
	Has keeping your home tidy been a problem (an area of need)? This could include cleaning and laundry. Are you getting the help you need? **Comments**				

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Met Need = this area is not a serious problem for me because of the help I am given

Unmet Need = this area remains a serious problem for me despite any help I am given

I Don't Want to Answer = I prefer not to respond

		No Need	Met Need	Unmet Need	I Don't Want to Answer
4.	**Self-Care**	☐	☐	☐	☐
	Has maintaining your personal hygiene been a problem (an area of need)? This could include challenges accessing or using products/facilities. Are you getting the help you need? **Comments**				
5.	**Daytime Activities**	☐	☐	☐	☐
	Have daytime activities been a problem (an area of need)? This could include work, education or leisure activities. Are you getting the help you need? **Comments**				
6.	**Physical Health**	☐	☐	☐	☐
	Has your physical health been a problem (an area of need)? Are you getting the help you need? **Comments**				
7.	**Psychotic Symptoms**	☐	☐	☐	☐
	Have symptoms of psychosis been a problem (an area of need)? These could include feeling like you're being watched or hearing voices that interfere with your daily life? Are you getting the help you need? **Comments**				
8.	**Information on Condition and Treatment**	☐	☐	☐	☐
	Has understanding your mental health condition and recommended services/treatments been a problem (an area of need)? Are you getting the information you need? **Comments**				
9.	**Psychological Distress**	☐	☐	☐	☐
	Have symptoms of depression or anxiety been a problem (an area of need)? These could include feelings of sadness or worry that interfere with your daily life. Are you getting the help you need? **Comments**				
10.	**Safety to Self**	☐	☐	☐	☐
	Have thoughts and/or acts of harming yourself been a problem area (an area of need)? Are you getting the help you need? **Comments**				

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I Don't Want to Answer = I prefer not to respond

		No Need	Met Need	Unmet Need	I Don't Want to Answer
11.	**Safety to Others**	☐	☐	☐	☐
	Have thoughts and/or acts of harming others been a problem area (an area of need)? Are you getting the help you need? **Comments**				
12.	**Alcohol**	☐	☐	☐	☐
	Has alcohol use been a problem (an area of need)? Are you getting the help you need? **Comments**				
13.	**Drugs**	☐	☐	☐	☐
	Has drug use been a problem (an area of need)? This could include illicit drugs or misuse of prescription drugs? Are you getting the help you need? **Comments**				
14.	**Other Addictions**	☐	☐	☐	☐
	Have other addictions been a problem (an area of need)? Other addictions could include gambling, overuse of electronic devices or smoking. Are you getting the help you need? **Comments**				
15.	**Company**	☐	☐	☐	☐
	Has your social life been a problem (an area of need)? Are you getting the help you need? **Comments**				
16.	**Intimate Relationships**	☐	☐	☐	☐
	Have close personal relationships been a problem (an area of need)? Are you getting the help you need? **Comments**				
17.	**Sexual Expression**	☐	☐	☐	☐
	Have your sex life and sexual health been a problem (an area of need)? Are you getting the help you need? **Comments**				
18.	**Child Care**	☐	☐	☐	☐
	Has looking after your children been a problem (area of need)? This could include access to child care or parenting. Are you getting the help you need? **Comments**				

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Met Need = this area is not a serious problem for me because of the help I am given

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I Don't Want to Answer = I prefer not to respond

		No Need	Met Need	Unmet Need	I Don't Want to Answer
19.	**Other Dependents**	☐	☐	☐	☐
	Has looking after other dependents been a problem (an area of need)? Other dependents could include elderly parents and pets. Are you getting the help you need? **Comments**				
20.	**Basic Education**	☐	☐	☐	☐
	Has reading, writing or basic math been a problem (an area of need)? Are you getting the help you need? **Comments**				
21.	**Telephone**	☐	☐	☐	☐
	Has accessing or using a phone or computer been a problem (an area of need)? Are you getting the help you need? **Comments**				
22.	**Transport**	☐	☐	☐	☐
	Has transportation been a problem (an area of need)? This could include getting to and from appointments and daily activities. Are you getting the help you need? **Comments**				
23.	**Money**	☐	☐	☐	☐
	Has managing your money been a problem (an area of need)? Are you getting the help you need? **Comments**				
24.	**Benefits**	☐	☐	☐	☐
	Has accessing the benefits/money you're entitled to been a problem (an area of need)? This could include Ontario Works, Disability Support Program and Drug Benefit. Are you getting the help you need? **Comments**				

Please write a few sentences to answer the following questions:

What are your strengths and skills?

What are your hopes and goals for the future?

What do you need to accomplish your hopes and goals?

Is spirituality an important part of your life? Please explain.

Is culture (heritage) an important part of your life? Please explain.

OCAN Staff Assessment

Using OCAN

OCAN is an assessment that helps to capture consumer views as a standard part of the discussions with their health worker(s). It is comprised of two main parts: the optional consumer self-assessment and the staff worker assessment. Where possible, it is recommended that the consumer be given the opportunity to complete their self-assessment**.** Completing both parts of the assessment will enable you and the consumer to have an informative discussion.

This is the Full OCAN which includes:

- the Consumer Self-Assessment
- the Staff Assessment and
- the Consumer Information Summary and Service Use

Start Date (YYYY-MM-DD)*: _____

Consumer Information Summary

1. OCAN Lead Assessment

OCAN completed by OCAN Lead?* ☐ Yes ☐ No

2. Reason for OCAN (select one)*

☐ Initial OCAN
☐ (Prior to) Discharge
☐ Reassessment
☐ Significant change (please specify) _____

3. Consumer Self Assessment Completion

3a. Was Consumer Self-Assessment completed?*

☐ Yes ☐ No

3b. If the Consumer Self-Assessment was not completed, why not? (select all that apply)

☐ Comfort level
☐ Language barrier
☐ Length of assessment
☐ Literacy
☐ Mental health condition
☐ Physical condition
☐ Other _____

4. Consumer Information

First Name:
Middle Initial:
Last Name:
Preferred Name:
Address:
City:
Province:
Postal Code:
Phone Number: Ext:
Email Address:

Date of Birth (YYYY-MM-DD):* ☐ Estimate ☐ Do not know
Health Card Number:
Version Code:
Issuing Territory:
Service Recipient Location (county, district, municipality):*
LHIN Consumer Resides in:*

4b. What is your gender? (select one)* ☐ Male ☐ Female ☐ Intersex ☐ Trans- Female to Male ☐ Trans- Male to Female ☐ Prefer not to answer ☐ Do not know ☐ Other (please specify) _____

4c. Marital Status (select one)*

☐ Single
☐ Partner or significant other
☐ Separated
☐ Prefer not to answer
☐ Married or in common-law relationship
☐ Widowed
☐ Divorced
☐ Do not know

5. Mental Health Functional Centre Use (for the last 6 months)

Mental Health Functional Centre 1		Mental Health Functional Centre 2	
OCAN Lead:*	☐ Yes ☐ No	**OCAN Lead:***	☐ Yes ☐ No
Staff Worker Name:*		**Staff Worker Name:***	
Staff Worker Phone Number:*	**Ext:**	**Staff Worker Phone Number:***	**Ext:**
Organization LHIN:*		**Organization LHIN:***	
Organization Name:*		**Organization Name:***	
Organization Number:*		**Organization Number:***	
Program Name:*		**Program Name:***	
Program Number:*		**Program Number:***	
Functional Centre Name:*		**Functional Centre Name:***	

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***HELP** (Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Do not know

**** Mandatory fields***

Functional Centre Number:*	**Functional Centre Number:***
Service Delivery LHIN:*	**Service Delivery LHIN:***
Referral Source:*	**Referral Source:***
Request for Service Date (YYYY-MM-DD):	**Request for Service Date (YYYY-MM-DD):**
Service Decision Date (YYYY-MM-DD):	**Service Decision Date (YYYY-MM-DD):**
Accepted:	**Accepted:**
Service Initiation Date (YYYY-MM-DD):	**Service Initiation Date (YYYY-MM-DD):**
Exit Date (YYYY-MM-DD):	**Exit Date (YYYY-MM-DD):**
Exit Disposition:	**Exit Disposition:**

Mental Health Functional Centre 3			**Mental Health Functional Centre 4**		
OCAN Lead:*	☐ Yes	☐ No	**OCAN Lead:***	☐ Yes	☐ No
Staff Worker Name:*			**Staff Worker Name:***		
Staff Worker Phone Number:*	**Ext:**		**Staff Worker Phone Number:***	**Ext:**	
Organization LHIN:*			**Organization LHIN:***		
Organization Name:*			**Organization Name:***		
Organization Number:*			**Organization Number:***		
Program Name:*			**Program Name:***		
Program Number:*			**Program Number:***		
Functional Centre Name:*			**Functional Centre Name:***		
Functional Centre Number:*			**Functional Centre Number:***		
Service Delivery LHIN:*			**Service Delivery LHIN:***		
Referral Source:*			**Referral Source:***		
Request for Service Date (YYYY-MM-DD):			**Request for Service Date (YYYY-MM-DD):**		
Service Decision Date (YYYY-MM-DD):			**Service Decision Date (YYYY-MM-DD):**		
Accepted:			**Accepted:**		
Service Initiation Date (YYYY-MM-DD):			**Service Initiation Date (YYYY-MM-DD):**		
Exit Date (YYYY-MM-DD):			**Exit Date (YYYY-MM-DD):**		
Exit Disposition:			**Exit Disposition:**		

6. Family Doctor Information

☐ Yes ☐ No ☐ None available ☐ Prefer not to answer ☐ Do not know

Name:	Address:
Phone Number:	City:
Ext:	Province:
Email Address:	Postal Code:
Last seen:	

7. Psychiatrist Information

☐ Yes ☐ No ☐ None available ☐ Prefer not to answer ☐ Do not know

Name:	Address:
Phone Number:	City:
Ext:	Province:
Email Address:	Postal Code:
Last seen:	

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***HELP** (Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Do not know

**** Mandatory fields***

8. Other Contact

☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

Contact Type:

Name: Address:

Phone Number: City:

Ext: Province:

Email Address: Postal Code:

Last seen:

Other Contact

☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

Contact Type:

Name: Address:

Phone Number: City:

Ext: Province:

Email Address: Postal Code:

Last seen:

9. Other Agency

☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

Name: Address:

Phone Number: City:

Ext: Province:

Email Address: Postal Code:

Last seen:

10. Consumer Capacity (select all that apply)

10a. Power of Attorney for Personal Care: ☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

Power of Attorney or SDM Name:

Address:

Phone Number: Ext:

10b. Power of Attorney for Property ☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

Power of Attorney:

Address:

Phone Number: Ext:

10c. Guardian ☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

Name:

Address:

Phone Number: Ext:

10d. Areas of Concern

Finance/property: ☐ Yes ☐ No ☐ Do not know

Treatment decisions: ☐ Yes ☐ No ☐ Do not know

11. Age in years for onset of mental illness:*	☐ Estimate	☐ Prefer not to answer	☐ Do not know	☐ N/A
12. Age of first psychiatric hospitalization:	☐ Estimate	☐ Prefer not to answer	☐ Do not know	☐ N/A
13. Most recent date consumer entered your organization (YYYY-MM):	☐ Estimate	☐ Prefer not to answer	☐ Do not know	☐ N/A

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**** Mandatory fields***

14. Which of the following best describe your racial or ethnic group? (select one)*

15. Citizenship Status (select one)

☐ Canadian citizen ☐ Temporary resident ☐ Prefer not to answer

☐ Permanent resident ☐ Refugee ☐ Do not know

16. Were you born in Canada?* ☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

If No, what year did you arrive in Canada? _____

17. Do you have any issues with your immigration experience? (select all that apply)

☐ None

☐ Lack of understanding of the Canadian system/resources

☐ Applying previous work experience/professional qualifications

☐ Separation from family members/significant others

☐ Family left behind in refugee camp

☐ Experience with war/incarceration/torture

☐ Refugee camp

☐ Experience with other trauma

☐ Other _____

☐ Prefer not to answer

☐ Do not know

18. Can you tell me about your immigration experience?

19. Experience of Discrimination (select all that apply)

☐ Disability ☐ Mental illness ☐ Other _____

☐ Ethnicity ☐ Race ☐ Prefer not to answer

☐ Gender ☐ Religion ☐ Do not know

☐ Immigration ☐ Sexual Orientation

20. What language would you feel most comfortable speaking in with your health care provider? (select one):*

21. Language of service provision:*

22. What is your mother tongue? (Select One)*

23. If your mother tongue is neither French nor English, which of Canada's official languages are you most comfortable?

24. Do you currently have any legal issues? (select all that apply)*

☐ Civil ☐ Criminal ☐ None ☐ Prefer not to answer ☐ Do not know

25. Comments on Legal Issue:

26. Current Legal Status (select all that apply)

Pre-Charge

☐ Pre-charge diversion

☐ Court diversion program

Pre-Trial

☐ Awaiting fitness assessment

☐ Awaiting trial *(with or without bail)*

☐ Awaiting criminal responsibility assessment (NCR)

☐ In community on own recognizance

☐ Unfit to stand trial

Outcomes

☐ Charges withdrawn

☐ Stay of proceedings

☐ Awaiting sentence

☐ NCR

☐ Conditional discharge

☐ Conditional sentence

☐ Restraining order

☐ Peace bond

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**** Mandatory fields***

☐ Suspended sentence

☐ Incarceration

Custody Status

☐ ORB detained – community access

☐ ORB conditional discharge

☐ On parole

☐ On probation

Other

☐ No legal problem *(includes absolute discharge and time served – end of custody)*

☐ Prefer not to answer

☐ Do not know

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***HELP** (Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Do not know

**** Mandatory fields***

Staff Assessment

1. Accommodation	Staff Rating
Are you happy with the place you live in or has it been a problem (an area of need)? Are you getting the help you need?	
1. Does the person lack a current place to stay?***** (*If rated 0 or 9, skip questions 2 & 3 and proceed to the additional questions below)*	
2. How much help with accommodation does the person receive from friends or relatives?	
3a. How much help with accommodation does the person receive from local services?	
3b. How much help with accommodation does the person need from local services?	
Comments:	

Action(s): By Whom:

Review date (YYYY-MM-DD):

Where do you live? (select one)*

- ☐ Approved homes & homes for special care
- ☐ Correctional/probation facility
- ☐ Domicillary hostel
- ☐ General hospital
- ☐ Psychiatric hospital
- ☐ Other specialty hospital
- ☐ No fixed address
- ☐ Hostel/shelter
- ☐ Long term care facility/nursing home
- ☐ Municipal non-profit housing
- ☐ Private non-profit housing
- ☐ Private house/Apt. – SR owned/market rent
- ☐ Private house/Apt. – other/subsidized
- ☐ Retirement home/senior's residence
- ☐ Rooming/boarding house
- ☐ Supportive housing – congregate living
- ☐ Supportive housing – assisted living
- ☐ Other _____
- ☐ Prefer not to answer
- ☐ Do not know

Do you receive any support? (select one)*

- ☐ Independent
- ☐ Assisted/supported
- ☐ Supervised non-facility
- ☐ Supervised facility
- ☐ Prefer not to answer
- ☐ Do not know

Do you live with anyone? (select all that apply)*

- ☐ No-on my own
- ☐ Spouse/partner
- ☐ Other
- ☐ Children
- ☐ Parents
- ☐ Prefer not to answer
- ☐ Non-relatives
- ☐ Relatives
- ☐ Do not know

2. Food	Staff Rating
Has getting food that suits your dietary needs been a problem (an area of need)? Are you getting the help you need?	
1. Does the person have difficulty in getting enough to eat?***** (*If rated 0 or 9, go to the next domain)*	
2. How much help with getting enough to eat does the person receive from friends or relatives?	
3a. How much help with getting enough to eat does the person receive from local services?	
3b. How much help with getting enough to eat does the person need from local services?	
Comments:	

NEED *(Q1):* 0 = No Need (No serious problem) / 1 = Met Need (No/Moderate problem due to help given) / 2 = Unmet Need (Serious problem) / 9 = Not known

HELP *(Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Do not know

**** Mandatory fields***

Action(s):	By Whom: Review Date (YYYY-MM-DD):

3. Looking After the Home	Staff Rating
Has keeping your home tidy been a problem (an area of need)? This could include cleaning and laundry. Are you getting the help you need?	
1. Does the person have difficulty looking after the home?***** (*If rated 0 or 9, go to the next domain)*	
2. How much help with looking after the home does the person receive from friends or relatives?	
3a. How much help with looking after the home does the person receive from local services?	
3b. How much help with looking after the home does the person need from local services?	
Comments:	

Action(s):	By Whom: Review Date (YYYY-MM-DD):

4. Self-Care	Staff Rating
Has maintaining your personal hygiene been a problem (an area of need)? This could include challenges accessing or using products/facilities. Are you getting the help you need?	
1. Does the person have difficulty with self-care? ***** (*If rated 0 or 9, go to the next domain)*	
2. How much help with self-care does the person receive from friends or relatives?	
3a. How much help with self-care does the person receive from local services?	
3b. How much help with self-care does the person need from local services?	
Comments:	

Action(s):	By Whom: Review Date (YYYY-MM-DD):

5. Daytime Activities	Staff Rating
Have daytime activities been a problem (an area of need)? This could include work, education or leisure activities. Are you getting the help you need?	
1. Does the person have difficulty with regular, appropriate daytime activities?***** (*If rated 0 or 9, skip questions 2 & 3 and proceed to the additional questions below)*	
2. How much help does the person receive from friends or relatives in finding and keeping regular and appropriate daytime activities?	
3a. How much help does the person receive from local services in finding and keeping regular and appropriate daytime activities?	
3b. How much help does the person need from local services in finding and keeping regular and appropriate daytime activities?	
Comments:	

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HELP *(Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Do not know

**** Mandatory fields***

Action(s): By Whom:

Review Date (YYYY-MM-DD):

What is your current employment status? (select one)*

☐ Independent/competitive
☐ Assisted/supportive
☐ Alternative businesses
☐ Sheltered workshop
☐ Non-paid work experience
☐ No employment – other activity
☐ Casual/sporadic
☐ No employment of any kind
☐ Prefer not to answer
☐ Do not know

Are you currently in school? (select one)*

☐ Not in school
☐ Elementary/junior high school
☐ Secondary/high school
☐ Trade school
☐ Vocational/training centre
☐ Adult education
☐ Community college
☐ University
☐ Other_____
☐ Prefer not to answer
☐ Do not know

Barriers in finding and/or maintaining a work/volunteer/education role (select all that apply)

☐ Addictions
☐ Cognitive abilities
☐ Confidence
☐ Contemplative
☐ Disclosure
☐ Financial ODSP cut off
☐ Funding for training
☐ Lack of resume
☐ Language comprehension
☐ Literacy
☐ Medication side effects
☐ Physical health
☐ Pre-contemplative
☐ Stigma
☐ Symptoms
☐ Transportation
☐ Other_____
☐ Prefer not to answer

Comments:

6. Physical Health	Staff Rating
Has your physical health been a problem (an area of need)? Are you getting the help you need?	
1. Does the person have any physical disability or any physical illness?* (*If rated 0 or 9, skip questions 2 & 3 and proceed to the additional questions below)*	
2. How much help does the person receive from friends or relatives for physical health problems?	
3a. How much help does the person receive from local services for physical health problems?	
3b. How much help does the person need from local services for physical health problems?	

Comments:

Action(s): By Whom:

Review Date (YYYY-MM-DD):

Medical Conditions (select all that apply)

This information is collected from a variety of sources, including self-report, and should not be used for diagnosis without being confirmed by a qualified diagnosing practitioner.

☐ Acquired Brain Injury (ABI)
☐ Alzheimer's
☐ Arthritis
☐ Autism
☐ Eating disorder
☐ Epilepsy
☐ Hearing impairment
☐ Heart condition
☐ Osteoporosis
☐ Pregnancy
☐ Seizure
☐ Sexually Transmitted Infection (STI)

Specify _____

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***HELP** (Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Do not know

**** Mandatory fields***

☐ Breathing problems
☐ Cancer
☐ Cirrhosis
☐ Communicable disease
☐ Diabetes
☐ Type 1 ☐ Type 3
☐ Type 2 ☐ Other
☐ Hepatitis
☐ A ☐ B ☐ C ☐ D
☐ HIV
☐ High blood pressure
☐ High cholesterol
☐ Intellectual disability
☐ Low blood pressure
☐ Obesity
☐ Skin conditions
☐ Sleep problems (e.g., insomnia)
☐ Stroke
☐ Thyroid
☐ Vision impairment
☐ Other _____
☐ Prefer not to answer
☐ Do not know

Comments:

List of all current medications (including prescribed and alternative/over the counter medication)
This information is collected from a variety of sources, including self-report, and should be confirmed by a qualified prescribing practitioner.

	Medication	Source of Information	Dosage, Frequency and Route	Taken as prescribed?	Help is provided?	Help is needed?
1				☐ Yes ☐ No ☐ Do not know	☐ Yes ☐ No ☐ Do not know	☐ Yes ☐ No ☐ Do not know
2				☐ Yes ☐ No ☐ Do not know	☐ Yes ☐ No ☐ Do not know	☐ Yes ☐ No ☐ Do not know
3				☐ Yes ☐ No ☐ Do not know	☐ Yes ☐ No ☐ Do not know	☐ Yes ☐ No ☐ Do not know
4				☐ Yes ☐ No ☐ Do not know	☐ Yes ☐ No ☐ Do not know	☐ Yes ☐ No ☐ Do not know
5				☐ Yes ☐ No ☐ Do not know	☐ Yes ☐ No ☐ Do not know	☐ Yes ☐ No ☐ Do not know

Medications – additional information:

7. Psychotic Symptoms

Have symptoms of psychosis been a problem (an area of need)? These could include feeling like you're being watched or hearing voices that interfere with your daily life? Are you getting the help you need?

	Staff Rating
1. Does the person have any psychotic symptoms?***** (*If rated 0 or 9, skip questions 2 & 3 and proceed to the additional questions below)*	
2. How much help does the person receive from friends or relatives for these psychotic symptoms?	
3a. How much help does the person receive from local services for these psychotic symptoms?	
3b. How much help does the person need from local services for these psychotic symptoms?	

Comments:

Action(s):

By Whom:

Review Date (YYYY-MM-DD):

***NEED** (Q1):* 0 = No Need (No serious problem) / 1 = Met Need (No/Moderate problem due to help given) / 2 = Unmet Need (Serious problem) / 9 = Not known

***HELP** (Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Do not know

**** Mandatory fields***

Psychiatric History

Have you been hospitalized due to your mental health during the past two years? (select one)*

☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

If Yes,

Total number of admissions for mental health reasons:

If Initial OCAN, list hospital admissions for the past 2 years OR if Reassessment, list hospital admissions since last OCAN

Total number of hospitalization days for mental health reasons:

If Initial OCAN, list total number of days spent in hospital for the past 2 years OR If Reassessment, list total number of days spent in hospital since last OCAN

How many times did you visit an Emergency Department in the last 6 months for mental health reasons?*

☐ None ☐ 2 - 5 ☐ Prefer not to answer

☐ 1 ☐ > 6 ☐ Do not know

Community Treatment Order:*

☐ Issued CTO ☐ No CTO ☐ Prefer not to answer ☐ Do not know

Psychiatric History – Additional Information:

Symptoms (select all that apply)
This information is collected from a variety of sources, including self-report, and should not be used for diagnosis without being confirmed by a qualified diagnosing practitioner.

☐ Agitation
Being emotionally disturbed or excited. Includes appearing disturbed, excited, restless or hyperactive

☐ Apathy
Lack of emotion or interest in things normally considered important

☐ Delusions
False personal beliefs that are not part of reality

☐ Difficulty in abstract thinking
Concrete thinking, cannot see the underlying meanings of things

☐ Disorganized thinking
Being unable to "think straight"

☐ Emotional unresponsiveness
Lack of normal feelings

☐ Grandiosity
Trying to seem very important

☐ Hallucinations
Sensing things that are not actually there

☐ Hostility
Acting unfriendly and showing ill feelings towards others

☐ Lack of drive or initiative
Lack of energy, desire or motivation to start or do anything even simple things

☐ Lack of spontaneity
Slow speech and actions

☐ Physical symptoms
Movements may slow down or stop

☐ Poor communication skills
Avoids eye contact and conversation

☐ Social withdrawal
Absorbed in own thoughts and senses

☐ Stereotype thinking
Strong attitudes and beliefs that may seem unreasonable to others

☐ Suspiciousness
Being untrusting and guarded

Comments:

8. Information on Condition and Treatment	Staff Rating
Has understanding your mental health condition and recommended services/treatments been a problem (an area of need)? Are you getting the information you need?	
1. Has the person had clear verbal or written information about condition and treatment?* (*If rated 0 or 9, skip questions 2 & 3 and proceed to the additional questions below)*	
2. How much help does the person receive from friends or relatives in obtaining such information?	
3a. How much help does the person receive from local services in obtaining such information?	

***NEED** (Q1):* 0 = No Need (No serious problem) / 1 = Met Need (No/Moderate problem due to help given) / 2 = Unmet Need (Serious problem) / 9 = Not known

***HELP** (Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Do not know

**** Mandatory fields***

3b. How much help does the person need from local services in obtaining such information?	

Comments:

Action(s): By Whom:

Review Date (YYYY-MM-DD):

Diagnostic categories (select all that apply)* **Source of Diagnosis (Select One)**

☐ Neurodevelopmental Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Schizophrenia Spectrum and Other Psychotic Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Bipolar and Related Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Depressive Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Anxiety Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Obsessive-Compulsive and Related Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Trauma- and Stressor-Related Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Dissociative Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Somatic Symptom and Related Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Feeding and Eating Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Elimination Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Sleep-Wake Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Sexual Dysfunctions	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Gender Dysphoria	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Disruptive, Impulse-Control, and Conduct Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Substance-Related and Addictive Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Neurocognitive Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Personality Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Paraphilic Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Other Mental Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Medication-Induced Movement Disorders and Other Adverse Effects of Medication	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both

☐ Not Applicable

☐ Prefer not to answer

☐ Do not know

Do you have any of the following disabilities? (Select all that apply)*

☐ Chronic Illness

☐ Drug or Alcohol Dependence

☐ Mental Illness

☐ Sensory Disability (i.e. hearing or vision loss)

☐ Prefer not to answer

☐ Do not know

☐ Development Disability

☐ Learning Disability

☐ Physical Disability

☐ None

☐ Other (Please specify): _____

***NEED** (Q1):* 0 = No Need (No serious problem) / 1 = Met Need (No/Moderate problem due to help given) / 2 = Unmet Need (Serious problem) / 9 = Not known

***HELP** (Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Do not know

**** Mandatory fields***

9. Psychological Distress	Staff Rating
Have symptoms of depression or anxiety been a problem (an area of need)? These could include feelings of sadness or worry that interfere with your daily life. Are you getting the help you need?	
1. Does the person suffer from current psychological distress?***** (*If rated 0 or 9, go to the next domain)*	
2. How much help does the person receive from friends or relatives for this distress?	
3a. How much help does the person receive from local services for this distress?	
3b. How much help does the person need from local services for this distress?	
Comments:	
Action(s): By Whom: Review Date (YYYY-MM-DD):	

10. Safety to Self	Staff Rating
Have thoughts and/or acts of harming yourself been a problem area (an area of need)? Are you getting the help you need?	
1. Is the person a danger to him or herself?***** (*If rated 0 or 9, skip questions 2 & 3 and proceed to the additional questions below)*	
2. How much help does the person receive from friends or relatives to reduce the risk of self-harm?	
3a. How much help does the person receive from local services to reduce the risk of self-harm?	
3b. How much help does the person need from local services to reduce the risk of self-harm?	
Comments:	
Action(s): By Whom: Review Date (YYYY-MM-DD):	

Have you attempted suicide in the past? (select one)

☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

Do you currently have suicidal thoughts? (select one)

☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

Do you have any concerns for your own safety? (select one)

☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

Risks (select all that apply)

☐ Abuse/neglect ☐ Exploitation risk

☐ Accidental self-harm ☐ Other _____

☐ Deliberate self-harm

11. Safety to Others	Staff Rating
Have thoughts and/or acts of harming others been a problem area (an area of need)? Are you getting the help you need?	
1. Is the person a current or potential risk to other people's safety?***** (*If rated 0 or 9, go to the next domain)*	
2. How much help does the person receive from friends or relatives to reduce the risk that he or she might harm someone else?	
3a. How much help does the person receive from local services to reduce the risk that he or she might harm someone else?	

***NEED** (Q1):* 0 = No Need (No serious problem) / 1 = Met Need (No/Moderate problem due to help given) / 2 = Unmet Need (Serious problem) / 9 = Not known

***HELP** (Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Do not know

**** Mandatory fields***

3b. How much help does the person need from local services to reduce the risk that he or she might harm someone else?	

Comments:

Action(s): By Whom:

Review Date (YYYY-MM-DD):

12. Alcohol	Staff Rating
Has alcohol use been a problem (an area of need)? Are you getting the help you need?	
1. Does the person drink excessively, or have a problem controlling his or her drinking?***** (*If rated 0 or 9, skip questions 2 & 3 and proceed to the additional questions below)*	
2. How much help does the person receive from friends or relatives for this drinking?	
3a. How much help does the person receive from local services for this drinking?	
3b. How much help does the person need from local services for this drinking?	

Comments:

Action(s): By Whom:

Review Date (YYYY-MM-DD):

How often do you drink alcohol (i.e., number of drinks)?

___ Drinks monthly ___ Drinks once a week ___ Drinks 2-3 times weekly ___ Drinks daily

Indicate the stage of change consumer is at – optional (select one)

☐ Precontemplation ☐ Contemplation ☐ Action ☐ Maintenance ☐ Relapse prevention

13. Drugs	Staff Rating
Has drug use been a problem (an area of need)? This could include illicit drugs or misuse of prescription drugs? Are you getting the help you need?	
1. Does the person have problems with drug misuse?***** (*If rated 0 or 9, skip questions 2 & 3 and proceed to the additional questions below)*	
2. How much help with drug misuse does the person receive from friends or relatives?	
3a. How much help with drug misuse does the person receive from local services?	
3b. How much help with drug misuse does the person need from local services?	

Comments:

Action(s): By Whom:

Review Date (YYYY-MM-DD):

Which of the following drugs have you used? (select all that apply)	Past 6 months	Ever
Marijuana	☐	☐
Cocaine (Crack)	☐	☐
Hallucinogens (e.g., LSD, PCP)	☐	☐
Stimulants (e.g., Amphetamines)	☐	☐
Opiates (e.g., Heroin)	☐	☐
Sedatives (not prescribed or not taken as prescribed - e.g., Valium)	☐	☐
Over-the-counter	☐	☐
	☐	☐

NEED *(Q1):* 0 = No Need (No serious problem) / 1 = Met Need (No/Moderate problem due to help given) / 2 = Unmet Need (Serious problem) / 9 = Not known

HELP *(Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Do not know

**** Mandatory fields***

Solvents	☐	☐
Other	☐	☐

Has the substance been injected?

Indicate the Stage of Change Consumer is at – Optional (select one)

☐ Precontemplation ☐ Contemplation ☐ Action ☐ Maintenance ☐ Relapse prevention

14. Other Addictions	Staff Rating
Have other addictions been a problem (an area of need)? Other addictions could include gambling, overuse of electronic devices or smoking. Are you getting the help you need?	
1. Does the person have problems with addictions?***** (*If rated 0 or 9, go to the next domain)*	
2. How much help with addictions does the person receive from friends or relatives?	
3a. How much help with addictions does the person receive from local services?	
3b. How much help with addictions does the person need from local services?	

Comments:

Action(s): By Whom:

Review Date (YYYY-MM-DD):

Type of addiction (select all that apply)

☐ Gambling ☐ Nicotine ☐ Other _____

Indicate the stage of change consumer is at – optional (select one)

☐ Precontemplation ☐ Contemplation ☐ Action ☐ Maintenance ☐ Relapse prevention

15. Company	Staff Rating
Has your social life been a problem (an area of need)? Are you getting the help you need?	
1. Does the person need help with social contact?***** (*If rated 0 or 9, skip questions 2 & 3 and proceed to the additional questions below)*	
2. How much help with social contact does the person receive from friends or relatives?	
3a. How much help does the person receive from local services in organizing social contact?	
3b. How much help does the person need from local services in organizing social contact?	

Comments:

Action(s): By Whom:

Review Date (YYYY-MM-DD):

16. Intimate Relationships	Staff Rating
Have close personal relationships been a problem (an area of need)? Are you getting the help you need?	
1. Does the person have any difficulty in finding a partner or in maintaining a close relationship?***** (*If rated 0 or 9, go to the next domain)*	
2. How much help with forming and maintaining close relationships does the person receive from friends or relatives?	
3a. How much help with forming and maintaining close relationships does the person receive from local services?	
3b. How much help with forming and maintaining close relationships does the person need from local services?	

NEED *(Q1):* 0 = No Need (No serious problem) / 1 = Met Need (No/Moderate problem due to help given) / 2 = Unmet Need (Serious problem) / 9 = Not known

HELP *(Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Do not know

**** Mandatory fields***

Comments:

Action(s): By Whom:

Review Date (YYYY-MM-DD):

17. Sexual Expression	Staff Rating
Have your sex life and sexual health been a problem (an area of need)? Are you getting the help you need?	
1. Does the person have problems with his or her sex life?***** (*If rated 0 or 9, go to the next domain)*	
2. How much help with problems in his or her sex life does the person receive from friends or relatives?	
3a. How much help with problems in his or her sex life does the person receive from local services?	
3b. How much help with problems in his or her sex life does the person need from local services?	

Comments:

Action(s): By Whom:

Review Date (YYYY-MM-DD):

What is your Sexual Orientation? (Select One)*

☐ Bisexual ☐ Gay ☐ Heterosexual ☐ Lesbian ☐ Queer ☐ Two-Spirit ☐ Prefer not to answer

☐ Do not know ☐ Other (please specify): _____

18. Child Care	Staff Rating
Has looking after your children been a problem (area of need)? This could include access to child care or parenting. Are you getting the help you need?	
1. Does the person have difficulty looking after his or her children?***** (*If rated 0 or 9, go to the next domain)*	
2. How much help with looking after the children does the person receive from friends or relatives?	
3a. How much help with looking after the children does the person receive from local services?	
3b. How much help with looking after the children does the person need from local services?	
Comments:	
Action(s): By Whom: Review Date (YYYY-MM-DD):	

19. Other Dependents	Staff Rating
Has looking after other dependents been a problem (an area of need)? Other dependents could include elderly parents and pets. Are you getting the help you need?	
1. Does the person have difficulty looking after other dependents?***** (*If rated 0 or 9, go to the next domain)*	
2. How much help with looking after other dependents does the person receive from friends or relatives?	
3a. How much help with looking after other dependents does the person receive from local services?	
3b. How much help with looking after other dependents the person need from local services?	
Comments:	

NEED *(Q1):* 0 = No Need (No serious problem) / 1 = Met Need (No/Moderate problem due to help given) / 2 = Unmet Need (Serious problem) / 9 = Not known

HELP *(Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Do not know

**** Mandatory fields***

Action(s):	By Whom: Review Date (YYYY-MM-DD):

20. Basic Education	Staff Rating
Has reading, writing or basic math been a problem (an area of need)? Are you getting the help you need?	
1. Does the person lack basic skills in numeracy and literacy?***** (*If rated 0 or 9, skip questions 2 & 3 and proceed to the additional questions below)*	
2. How much help with numeracy and literacy does the person receive from friends or relatives?	
3a. How much help with numeracy and literacy does the person receive from local services?	
3b. How much help with numeracy and literacy does the person need from local services?	
Comments:	

Action(s):	By Whom: Review Date (YYYY-MM-DD):

What is your highest level of education? (select one)*

☐ No formal schooling	☐ Some secondary/high school	☐ College/university
☐ Some elementary/junior high school	☐ Secondary/high school	☐ Prefer not to answer
☐ Elementary/junior high school	☐ Some college/university	☐ Do not know

21. Telephone	Staff Rating
Has accessing or using a phone or computer been a problem (an area of need)? Are you getting the help you need?	
1. Does the person have any difficulty in getting access to or using a telephone?***** (*If rated 0 or 9, go to the next domain)*	
2. How much help does the person receive from friends or relatives to make telephone calls?	
3a. How much help does the person receive from local services to make telephone calls?	
3b. How much help does the person need from local services to make telephone calls?	
Comments:	

Action(s):	By Whom: Review Date (YYYY-MM-DD):

22. Transport	Staff Rating
Has transportation been a problem (an area of need)? This could include getting to and from appointments and daily activities. Are you getting the help you need?	
1. Does the person have any problems using public transport?***** (*If rated 0 or 9, go to the next domain)*	
2. How much help with travelling does the person receive from friends or relatives?	
3a. How much help with travelling does the person receive from local services?	
3b. How much help with travelling does the person need from local services?	
Comments:	

NEED *(Q1):* 0 = No Need (No serious problem) / 1 = Met Need (No/Moderate problem due to help given) / 2 = Unmet Need (Serious problem) / 9 = Not known

HELP *(Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Do not know

**** Mandatory fields***

Action(s):	By Whom: Review Date (YYYY-MM-DD):

23. Money ***Has managing your money been a problem (an area of need)? Are you getting the help you need?***	Staff Rating
1. Does the person have problems budgeting his or her money?***** (*If rated 0 or 9, skip questions 2 & 3 and proceed to the additional questions below)*	
2. How much help does the person receive from friends or relatives in managing his or her money?	
3a. How much help does the person receive from local services in managing his or her money?	
3b. How much help does the person need from local services in managing his or her money?	
Comments:	

Action(s):	By Whom: Review Date (YYYY-MM-DD):

What is your primary source of income? (select one)*

☐ Employment	☐ Social Assistance	☐ Other _____
☐ Employment Insurance	☐ Disability Assistance	☐ Prefer not to answer
☐ Pension	☐ Family	☐ Do not know
☐ ODSP	☐ No Source of Income	

What is your total Family Income before taxes last year? (Select One)*

☐ $0 – $19,999	☐ $120,000 - $149,999
☐ $20,000 – $29,999	☐ Prefer not to answer
☐ $30,000 - $59,999	☐ Do not know
☐ $60,000 - $ 89,999	
☐ $90,000 - $119,999	

How many people does this income support?*

_____ **person(s)** ☐ Prefer not to answer ☐ Do not know

24. Benefits ***Has accessing the benefits/money you're entitled to been a problem (an area of need)? This could include Ontario Works, Disability Support Program and Drug Benefit. Are you getting the help you need?***	Staff Rating
1. Is the person definitely receiving all the benefits that he or she is entitled to?***** (*If rated 0 or 9, go to the next section)*	
2. How much help does the person receive from friends or relatives in obtaining the full benefit entitlement?	
3a. How much help does the person receive from local services in obtaining the full benefit entitlement?	
3b. How much help does the person need from local services in obtaining the full benefit entitlement?	
Comments:	

Action(s):	By Whom: Review Date (YYYY-MM-DD):

***NEED** (Q1):* 0 = No Need (No serious problem) / 1 = Met Need (No/Moderate problem due to help given) / 2 = Unmet Need (Serious problem) / 9 = Not known

***HELP** (Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Do not know

**** Mandatory fields***

What are your strengths and skills?

What are your hopes and goals for the future?

What do you need to accomplish your hopes and goals?

Is spirituality an important part of your life? Please explain.

Is culture (heritage) an important part of your life? Please explain.

Presenting Issues* (select all that apply)

- ☐ Activities of daily living
- ☐ Attempted suicide
- ☐ Educational
- ☐ Financial
- ☐ Housing
- ☐ Legal
- ☐ Occupational/employment/vocational
- ☐ Physical abuse
- ☐ Problems with addictions
- ☐ Problems with relationships
- ☐ Problems with substance abuse
- ☐ Sexual abuse
- ☐ Specific symptom of serious mental illness
- ☐ Threat to others
- ☐ Threat to self
- ☐ Other _____

Summary of Actions

Priority	Domain	Action(s)

Summary of Referrals

Optimal Referral	Specify	Actual Referral	Specify	Reasons for Difference	Referral Status

Completion Date (YYYY-MM-DD)*: _____

***NEED** (Q1):* 0 = No Need (No serious problem) / 1 = Met Need (No/Moderate problem due to help given) / 2 = Unmet Need (Serious problem) / 9 = Not known

***HELP** (Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Do not know

**** Mandatory fields***