Ontario Common Assessment of Need (OCAN)

Part II: Staff Assessment

v1.0.1

CCIM Community Care Information Management
ACCESS TO INFORMATION

OCAN Staff Assessment

Using OCAN

OCAN is an assessment that helps to capture consumer views as a standard and formal part of their discussions with their health worker(s). It is comprised of 2 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 as the first part of the process. Following the consumer self-assessment, you will need to complete the staff worker assessment. Completing both parts of the assessment will enable you and your consumer to have an informative discussion. If you wish, you also have access to a staff assessment with examples for all the questions asked in each domain.

Important points to communicate to your consumer:

Use of consumer responses

The answers consumers provide to questions in OCAN will be used to help them get the support they need. This information may only be used and shared with other agencies if they agree. A consumer may refuse to share any information they wish, and may change their mind at a later time. Choosing not to complete OCAN will not prevent consumers from receiving services.

- Information collected using the self-assessment belongs to them.
- Sharing that information can be an essential part of getting the services they need.
- They decide how and when their information is used and shared with others.

Consumer consent

The agency will provide a consent form to consumers with the OCAN. The consent is the place for them to indicate their desire to use OCAN and how they want their information to be shared with others.

Start Date: _____

Service Organization Name:
Service Organization Number:
Program Name:
Program Number:
Function (MIS Functional Centre):

Name:
Address:

Telephone Number: Email Address:

OHIP Number:

Reason for Assessment (select one)

☐ Initial assessment
☐ Reassessment at 6 months
☐ (Prior to) discharge
☐ Other (significant change, client request)
Specify _____

Doctor: ☐ Yes ☐ No ☐ None available — Contact information: Last seen:

Psychiatrist: ☐ Yes ☐ No ☐ None available — Contact information: Last seen:

Other contact: — Contact information: Last seen:

Other contact: — Contact information: Last seen:

Other agency: — Contact information: Last seen:

Service Recipient Location (county, district, municipality): Service Delivery LHIN:
Service Recipient LHIN: Date of Birth – Age:

Gender (select one)

☐ Female ☐ Male ☐ Other ☐ Unknown ☐ Client declined to answer

Marital Status (select one)

☐ Single ☐ Partner or significant other ☐ Separated ☐ Unknown
☐ Married or in common-law relationship ☐ Widowed ☐ Divorced ☐ Client declined to answer

Client Capacity Status (check all that apply)

Does the client have a Power of Attorney for property? Contact information:
☐ Yes ☐ No ☐ Unknown ☐ Client declined to answer

Does the client have a Power of Attorney or a substitute decision maker for personal care? Contact Information:
☐ Yes ☐ No ☐ Unknown ☐ Client declined to answer

Does the client have a court appointed guardian? Contact Information:
☐ Yes ☐ No ☐ Unknown ☐ Client declined to answer

Who referred you to this service? (select one)

☐ General hospital
☐ Psychiatric hospital
☐ Other institution
☐ Community Mental Health and Addiction organization
☐ Other community agencies
☐ Other
☐ Family physicians
☐ Psychiatrists
☐ Mental health worker
☐ Criminal justice worker
☐ Self, family or friend

What culture do you identify with?

Aboriginal Origin (select one)

☐ Aboriginal ☐ Non-aboriginal ☐ Unknown ☐ Client declined to answer

Citizenship Status (select one)

☐ Canadian citizen ☐ Temporary resident ☐ Unknown
☐ Permanent resident ☐ Refugee ☐ Client declined to answer

Length of time lived in Canada (Number of years/months):

Can you tell me about your immigration experience?

Do you have any issues with your immigration experience? (check 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 _____
☐ Unknown
☐ Client declined to answer

Experience of Discrimination (check all that apply)

☐ Disability ☐ Mental illness ☐ Other _____
☐ Ethnicity ☐ Race ☐ Unknown
☐ Gender ☐ Religion ☐ Client declined to answer
☐ Immigration ☐ Sexual orientation

Service Recipient Preferred Language:
Language of Service Provision:

Do you have any legal issues? (select one)

☐ Civil ☐ Criminal ☐ None ☐ Unknown ☐ Client declined to answer

Legal Status (check 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

Custody Status
☐ ORB detained – community access
☐ ORB conditional discharge
☐ On parole
☐ On probation

Outcomes
☐ Charges withdrawn
☐ Stay of proceedings
☐ Awaiting sentence
☐ NCR
☐ Conditional discharge
☐ Conditional sentence
☐ Restraining order
☐ Peace bond
☐ Suspended sentence

Other
☐ No legal problem *(includes absolute discharge and time served – end of custody)*
☐ Unknown
☐ Client declined to answer

Exit Disposition? (select one if applicable)

☐ Completion without referral ☐ Suicides ☐ Relocation
☐ Completion with referral ☐ Death ☐ Withdrawal

Comments:

1. Accommodation *What kind of place do you live in? What sort of place is it?*	Staff Rating
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:	

Where do you live? (select one)

☐ Approved Homes & Homes for Special Care	☐ Private non-profit housing
☐ Correctional/probation facility	☐ Private House/Apt. – SR owned/market rent
☐ Domiciliary hostel	☐ Private House/Apt. – other/subsidized
☐ General hospital	☐ Retirement home/senior's residence
☐ Psychiatric hospital	☐ Rooming/boarding house
☐ Other specialty hospital	☐ Supportive Housing – Congregate Living
☐ No fixed address	☐ Supportive Housing – Assisted Living
☐ Hostel/shelter	☐ Other
☐ Long term care facility/nursing home	☐ Unknown
☐ Municipal non-profit housing	☐ Client declined to respond

Do you receive any support? (select one)

☐ Independent	☐ Supervised non-facility	☐ Unknown
☐ Assisted/supported	☐ Supervised facility	☐ Client declined to answer

Do you live with anyone? (select one)

☐ Self	☐ Children	☐ Non-relatives
☐ Spouse/partner	☐ Parents	☐ Unknown
☐ Spouse/partner and others	☐ Relatives	☐ Client declined to answer

2. Food *What kind of food do you eat? Are you able to prepare your own meals and do your own shopping?*	Staff Rating
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:	
Action(s): By whom: Review date:	

3. Looking after the home *Are you able to look after your home? Does anyone help you?*	Staff Rating
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:	

4. Self-care *Do you have problems keeping clean and tidy? Do you ever need reminding? Who by?*	Staff Rating
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:	

5. Daytime activities *How do you spend your day? Do you have enough to do?*	Staff Rating
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:	
Action(s): By whom: Review date:	

What is your current employment status? (select one)

☐ Independent/competitive	☐ Non-paid work experience	☐ Unknown
☐ Assisted/supportive	☐ No employment – other activity	☐ Client declined to answer
☐ Alternative businesses	☐ Casual/sporadic	
☐ Sheltered workshop	☐ No employment of any kind	

Are you currently in school? (select one)

☐ Not in school	☐ Vocational/training centre	☐ Other
☐ Elementary/junior high school	☐ Adult education	☐ Unknown
☐ Secondary/high school	☐ Community college	☐ Client declined to answer
☐ Trade school	☐ University	

Are you at risk of unemployment or disrupted education? (check all that apply)

☐ Difficulty in getting to work/school on time	☐ Looking to quit work/school	☐ Unknown
	☐ Frequent changes in work/school	☐ Client declined to answer
☐ Problems/difficulty in work/school	☐ None or not applicable	

6. Physical Health *How well do you feel physically? Are you getting any treatment for physical problems?*	Staff Rating
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:

Medical conditions (check all that apply)

☐ Acquired Brain Injury (ABI)
☐ Arthritis
☐ Autism
Specify _____
☐ Breathing problems
☐ Cancer
☐ Cirrhosis
☐ Communicable health disease
Diabetes
☐ Type 1 ☐ Type 3
☐ Type 2 ☐ Other
☐ Eating disorder
☐ Epilepsy
☐ Hearing impairment
☐ Heart condition
Hepatitis
☐ A ☐ B ☐ C
☐ HIV
☐ High blood pressure
☐ High cholesterol
☐ Intellectual disability
☐ Low blood pressure
☐ MRSA, C Difficile
☐ Obesity
☐ Osteoporosis
☐ Pregnancy
☐ Seizure
☐ Sexually Transmitted Disease (STD)
☐ Skin conditions
☐ Stroke
☐ Thyroid
☐ Vision impairment
☐ Other
Specify _____
☐ Unknown
☐ Client declined to answer

Do you have any concerns about your physical health?

☐ Yes ☐ No ☐ Unknown ☐ Client declined to answer

If Yes, please indicate the areas where you have concerns (check all that apply)

☐ Head and neck
☐ Chest
☐ Abdomen
☐ Extremities (arms, legs, hands, feet)
☐ Genital/urinary
☐ Skin
☐ Joints
☐ Mobility
☐ Neurological
☐ Hearing
☐ Vision
☐ Other _____

List of all current medications (including prescribed and alternative/over the counter medication)

	Medication	**Dosage**	**Taken as prescribed?**			**Help is provided?**			**Help is needed?**		
1			☐ Yes	☐ No	☐ Unknown	☐ Yes	☐ No	☐ Unknown	☐ Yes	☐ No	☐ Unknown
2			☐ Yes	☐ No	☐ Unknown	☐ Yes	☐ No	☐ Unknown	☐ Yes	☐ No	☐ Unknown
3			☐ Yes	☐ No	☐ Unknown	☐ Yes	☐ No	☐ Unknown	☐ Yes	☐ No	☐ Unknown
4			☐ Yes	☐ No	☐ Unknown	☐ Yes	☐ No	☐ Unknown	☐ Yes	☐ No	☐ Unknown
5			☐ Yes	☐ No	☐ Unknown	☐ Yes	☐ No	☐ Unknown	☐ Yes	☐ No	☐ Unknown

Medications – additional information:

Reports side effects? (select one)

☐ Yes ☐ No ☐ Unknown ☐ Client declined to answer

Do these side effects affect your daily living? (select one)

☐ Yes ☐ No ☐ Unknown ☐ Client declined to answer

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

***HELP** (Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Unknown

Description of side effects (check all that apply)

☐ None	☐ Fast heart beat	☐ Numbness / tingling
☐ Blurred / dimmed vision	☐ Gastrointestinal distress	☐ Restlessness
☐ Changes in appetite	☐ Headache	☐ Sexual disturbance
☐ Dizziness / spinning	☐ Insomnia	☐ Tremors / rigidity / balance problems
☐ Drowsiness / sedation	☐ Menstrual changes	☐ Weight gain
☐ Dry mouth	☐ Milky discharge from breasts	☐ Other _____
☐ Fatigue / weakness	☐ Muscle spasms	

7. Psychotic symptoms *Do you ever hear voices, or have problems with your thoughts? Are you on any medication or injections? What is it for?*	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:

Psychiatric history

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

☐ Yes ☐ No ☐ Unknown ☐ Client declined to answer

If Yes, Total Number of Admissions (last two years):
Total Number of Hospitalization Days (last two years):

Community Treatment Order:

☐ Issued CTO ☐ No CTO ☐ Unknown ☐ Client declined to answer

Psychiatric History – additional information:

Symptom checklist

☐ None	☐ Guilt/shame	☐ Racing thoughts
☐ Abnormal affect	☐ Hallucinations	☐ Rapid mood changes
☐ Abnormal thought process/form	☐ Hopelessness	☐ Reliving traumatic memories
☐ Anger	☐ Hygiene	☐ Self-deprecation
☐ Anxiety	☐ Inability to experience joy/pleasure	☐ Sleep problems
☐ Command hallucinations	☐ Inflated self-worth	☐ Tearfulness
☐ Compulsive behaviour	☐ Intrusive thoughts	☐ Unusual or abnormal physical movements
☐ Decreased energy	☐ Irritability	☐ Unknown
☐ Delusions	☐ Obsessive thoughts	☐ Other
☐ Episodes of panic	☐ Phobias	Specify _____
☐ Fears	☐ Pressured speech	

8. Information on condition and treatment *Have you been given clear information about your medication or other treatment? How helpful has the information been?*	Staff Rating
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?	
3b. How much help does the person need from local services in obtaining such information?	

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

***HELP** (Q2 and 3a/b):* 0 = None / 1 = Low help / 2 = Moderate help 3 = High help / 9 = Unknown

Comments:

Action(s): By whom:
Review date:

Diagnostic categories (check all that apply)

☐ Adjustment Disorders
☐ Anxiety Disorder
☐ Delirium, Dementia, and Amnestic and Cognitive Disorders
☐ Disorder of Childhood/Adolescence
☐ Dissociative Disorders
☐ Eating Disorders
☐ Factitious Disorders
☐ Impulse Control Disorders not elsewhere classified
☐ Mental Disorders due to General Medical Conditions
☐ Mood Disorder
☐ Personality Disorders
☐ Schizophrenia and other psychotic disorders
☐ Sexual and Gender Identity Disorders
☐ Sleep Disorders
☐ Somatoform Disorders
☐ Substance Related Disorders
☐ Developmental Handicap
☐ Unknown
☐ Client declined to answer

Other Illness Information (check all that apply)

☐ Concurrent Disorder (substance abuse)
☐ Dual Diagnosis (developmental disability)
☐ Other chronic illnesses and/or physical disabilities

9. Psychological distress *Have you recently felt very sad or low? Have you felt overly anxious or frightened?*	Staff Rating
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:	

10. Safety to self *Do you ever have thoughts of harming yourself, or actually harm yourself? Do you put yourself in danger in other ways?*	Staff Rating
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:	

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

☐ Yes ☐ No ☐ Unknown ☐ Client declined to answer

Do you currently have suicidal thoughts? (select one)

☐ Yes ☐ No ☐ Unknown ☐ Client declined to answer

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

☐ Yes ☐ No ☐ Unknown ☐ Client declined to answer

Risks (select all that apply)

☐ Abuse/neglect
☐ Accidental self-harm
☐ Deliberate self-harm
☐ Exploitation risk
☐ Other _____

11. Safety to others *Do you think you could be a danger to other people's safety? Do you ever lose your temper and hit someone?*	Staff Rating
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?	
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:

12. Alcohol *Does drinking cause you any problems? Do you wish you could cut down your drinking?*	Staff Rating
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:

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

___ drinks monthly ___ drinks weekly ___ drinks 2-3 times weekly ___ drinks daily

Indicate the stage of change client is at – Optional (select one)

☐ Precontemplation ☐ Contemplation ☐ Action ☐ Maintenance ☐ Relapse Prevention

How has drinking had an impact on your life?

13. Drugs *Do you take drugs that aren't prescribed? Are there any drugs you would find hard to stop taking?*	Staff Rating
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:

Which of the following drugs have you used? (check 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	☐	☐
Solvents	☐	☐
Other	☐	☐
Has the substance been injected?	☐	☐

Indicate the stage of change client is at – Optional (select one)

☐ Precontemplation ☐ Contemplation ☐ Action ☐ Maintenance ☐ Relapse Prevention

How has the substance(s) of choice had an impact on your life?

14. Other addictions *Do you have an addiction? Is your addiction a problem?*	Staff Rating
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:

Type of addiction (check all that apply)

☐ Gambling ☐ Nicotine ☐ Other _____

Indicate the stage of change client is at – Optional (select one)

☐ Precontemplation ☐ Contemplation ☐ Action ☐ Maintenance ☐ Relapse Prevention

How has the addiction had an impact on your life?

15. Company *Are you happy with your social life? Do you wish you had more contact with others?*	Staff Rating
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:

Have there been any changes to your social patterns recently?

☐ Yes ☐ No ☐ Unknown ☐ Client declined to answer

16. Intimate relationships *Do you have a partner? Do you have problems in your partnership/marriage?*	Staff Rating
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?	
Comments:	

Action(s):	By whom: Review date:

17. Sexual expression *How is your sex life?*	Staff Rating
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:

18. Child care *Do you have any children under 18? Do you have any difficulty in looking after them?*	Staff Rating
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:

19. Other dependents *Do you have any dependents other than children under 18, such as an elderly parent or beloved pet?* *Do you have any difficulty in looking after them?*	Staff Rating
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:	
Action(s): By whom: Review date:	

20. Basic education *Do you have difficulty in reading, writing, speaking or understanding English? Any other languages?*	Staff Rating
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:	

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

☐ No formal schooling
☐ Some Elementary/Junior High School
☐ Elementary/Junior High School
☐ Some Secondary/High School
☐ Secondary/High School
☐ Some College/University
☐ College/University
☐ Unknown
☐ Client declined to answer

21. Telephone *Do you know how to use a telephone? Is it easy to find one that you can use?*	Staff Rating
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:	

22. Transport *Do you have access to transportation? Do you have access to other affordable transportation methods?*	Staff Rating
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:	

Action(s):	By whom: Review date:

23. Money *How do you find budgeting your money? Do you manage to pay your bills?*	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:

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

☐ Employment	☐ Social Assistance	☐ Other
☐ Employment insurance	☐ Disability Assistance	☐ Unknown
☐ Pension	☐ Family	☐ Client declined to answer
☐ ODSP	☐ No source of income	

24. Benefits *Are you sure that you are getting all the money you are entitled to?*	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:

What are your hopes for the future?

What do you think you need in order to get there?

How do you view your mental health?

Is spirituality an important part of your life?

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

Presenting Issues

- ☐ Threat to others/attempted suicide
- ☐ Specific symptom of serious mental illness
- ☐ Physical/sexual abuse
- ☐ Educational
- ☐ Occupational/Employment/Vocational
- ☐ Housing
- ☐ Financial
- ☐ Legal
- ☐ Problems with relationships
- ☐ Problems with substance abuse/addictions
- ☐ Activities of daily living
- ☐ Other

Summary of actions

Priority	Domain	Action(s)

Summary of referrals

Optimal Referral	Specify	Actual Referral	Specify	Reasons for Difference	Referral Status

Completion Date: _____