

# ***Ontario Common Assessment of Need (OCAN)***

Community Mental Health Common Assessment Project



## **Core + Self OCAN 2.0**

Revision 2.0.5

# O CAN Consumer Self-Assessment

## Welcome to this opportunity to speak with your own voice

This agency is providing you the opportunity to complete the O CAN Consumer Self-assessment. This formal process is becoming standard across the province to ensure consumers' views about their needs are heard.

## Why we would like you to take this opportunity:

- You can choose to bring this information to other agencies to reduce the number of times you have to answer questions. These questions are becoming common to all community mental health agencies.
- Agencies can work with you to better find the right help the first time because it asks a broad set of questions to cover all your needs.
- You can fully discuss your needs. The answers you give will help determine what services you will receive, and how to prioritize your goals.
- You can record your comments in every section, as well as your hopes, dreams and goals so that a plan can be developed to help you get there.

You decide how many of the questions you answer and the amount of time you need to complete it. You can decide whether or not you want some help, and choose this help from a number of options including a peer support worker, other trusted worker, family, friends, etc. You also have the option to answer some or all of the questions.

<b>Name:</b>	
<b>Date of Birth (YYYY-MM-DD):</b>	
<b>Start Date (YYYY-MM-DD):</b>	<b>Completion Date (YYYY-MM-DD):</b>
<p><b><u>INSTRUCTIONS:</u></b></p> <p>When you have completed this assessment, your worker will have a conversation with you about your needs.</p> <ul style="list-style-type: none"> <li>Please let your worker know if you have completed a Common Assessment in the last six months.</li> <li>Please read the pamphlet provided on how your information will be used.</li> <li>Please ask about any questions you don't understand.</li> </ul> <p style="text-align: center;">Please ✓ <u>tick one box</u> in each row (24 in total) using the following key:</p>	
<b>No Need</b> = this area is not a serious problem for me at all	
<b>Met Need</b> = this area is not a serious problem for me because of the help I am given	
<b>Unmet Need</b> = this area remains a serious problem for me despite any help I am given	

		No Need	Met Need	Unmet Need	I Don't Want to Answer
1.	<b>Accommodation</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	What kind of place do you live in? <b>Comments</b>				
2.	<b>Food</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Do you get enough to eat? <b>Comments</b>				
3.	<b>Looking After the Home</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Are you able to look after your home? <b>Comments</b>				
4.	<b>Self-Care</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Do you have problems keeping clean and tidy? <b>Comments</b>				
5.	<b>Daytime Activities</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	How do you spend your day? <b>Comments</b>				
6.	<b>Physical Health</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	How well do you feel physically? <b>Comments</b>				

**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

		No Need	Met Need	Unmet Need	I Don't Want to Answer
7.	<b>Psychotic Symptoms</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Do you ever hear voices or have problems with your thoughts? <b>Comments</b>				
8.	<b>Information on Condition and Treatment</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Have you been given clear information about your medication? <b>Comments</b>				
9.	<b>Psychological Distress</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Have you recently felt very sad or low? <b>Comments</b>				
10.	<b>Safety to Self</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Do you ever have thoughts of harming yourself? <b>Comments</b>				
11.	<b>Safety to Others</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Do you think you could be a danger to other people's safety? <b>Comments</b>				
12.	<b>Alcohol</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Does drinking cause you any problems? <b>Comments</b>				
13.	<b>Drugs</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Do you take any drugs that aren't prescribed? <b>Comments</b>				
14.	<b>Other Addictions</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Do you have any other addictions – such as gambling? <b>Comments</b>				
15.	<b>Company</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Are you happy with your social life? <b>Comments</b>				

<b>No Need</b> = this area is not a serious problem for me at all					
<b>Met Need</b> = this area is not a serious problem for me because of the help I am given					
<b>Unmet Need</b> = this area remains a serious problem for me despite any help I am given					
		No Need	Met Need	Unmet Need	I Don't Want to Answer
16.	<b>Intimate Relationships</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Do you have a partner? <b>Comments</b>				
17.	<b>Sexual Expression</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	How is your sex life? <b>Comments</b>				
18.	<b>Child Care</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Do you have any children under 18? <b>Comments</b>				
19.	<b>Other Dependents</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Do you have any dependents other than children under 18, such as an elderly parent or beloved pet? <b>Comments</b>				
20.	<b>Basic Education</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Any difficulty in reading, writing or understanding English? <b>Comments</b>				
21.	<b>Telephone</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Do you know how to use a telephone? <b>Comments</b>				
22.	<b>Transport</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	How do you find using the bus, streetcar or train? <b>Comments</b>				
23.	<b>Money</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	How do you find budgeting your money? <b>Comments</b>				
24.	<b>Benefits</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Are you getting all the money you are entitled to? <b>Comments</b>				

***Please write a few sentences to answer the following questions:***

**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?**

## CORE + Self OCAN

### Using CORE + Self OCAN

This agency is using the CORE + Self OCAN which provides consumers the opportunity to complete the OCAN Consumer Self-assessment to ensure consumers' views about their needs are heard. It also includes the Consumer Information Summary and Service Use sections of OCAN which capture the information that this agency reports as a community mental health service provider.

### Important points to communicate to the 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 represents their view of where they are today.
- 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 (YYYY-MM-DD)\*: \_\_\_\_\_

## Consumer Information Summary

### 1. OCAN Lead Assessment

OCAN completed by OCAN Lead?\* ☐ Yes ☐ No

### 2. Reason for OCAN (select one)\*

- |  |   |
|--|---|
| <input type="checkbox"/> Initial OCAN<br><input type="checkbox"/> Reassessment<br><input type="checkbox"/> (Prior to) Discharge<br><input type="checkbox"/> Significant change | <input type="checkbox"/> Review<br><input type="checkbox"/> Re-key<br><input type="checkbox"/> Other (e.g., consumer request)<br>Please specify _____ |
|--|---|

### 3. Consumer Information

First Name:	Date of Birth (YYYY-MM-DD):*	<input type="checkbox"/> Estimate	<input type="checkbox"/> Unknown
Middle Initial:	Health Card Number:		
Last Name:	Version Code:		
Preferred Name:	Issuing Territory:		
Address:	Service Recipient Location (county, district, municipality):*		
City:	LHIN Consumer Resides in:*		
Province:			
Postal Code:			
Phone Number:	Ext:		
Email Address:			

3b. Gender (select one)\* ☐ Male ☐ Female ☐ Other ☐ Consumer declined to answer ☐ Unknown

### 3c. Marital Status (select one)

- |  |   |                                    |  |
|--|---|------------------------------------|--|
| <input type="checkbox"/> Single                                | <input type="checkbox"/> Partner or significant other | <input type="checkbox"/> Separated | <input type="checkbox"/> Consumer declined to answer |
| <input type="checkbox"/> Married or in common-law relationship | <input type="checkbox"/> Widowed                      | <input type="checkbox"/> Divorced  | <input type="checkbox"/> Unknown                     |

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

Mental Health Functional Centre 1	Mental Health Functional Centre 2
OCAN Lead:* <input type="checkbox"/> Yes <input type="checkbox"/> No	OCAN Lead:* <input type="checkbox"/> Yes <input type="checkbox"/> 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:

\* Mandatory fields



<b>Service Initiation Date (YYYY-MM-DD):</b> <b>Exit Date (YYYY-MM-DD):</b> <b>Exit Disposition:</b>	<b>Service Initiation Date (YYYY-MM-DD):</b> <b>Exit Date (YYYY-MM-DD):</b> <b>Exit Disposition:</b>
<b>Mental Health Functional Centre 3</b>	<b>Mental Health Functional Centre 4</b>
<b>OCAN Lead:*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Staff Worker Name:*</b> <b>Staff Worker Phone Number:*</b> <b>Ext:</b> <b>Organization LHIN:*</b> <b>Organization Name:*</b> <b>Organization Number:*</b> <b>Program Name:*</b> <b>Program Number:*</b> <b>Functional Centre Name:*</b> <b>Functional Centre Number:*</b> <b>Service Delivery LHIN:*</b> <b>Referral Source:*</b> <b>Request for Service Date (YYYY-MM-DD):</b> <b>Service Decision Date (YYYY-MM-DD):</b> <b>Accepted:</b> <b>Service Initiation Date (YYYY-MM-DD):</b> <b>Exit Date (YYYY-MM-DD):</b> <b>Exit Disposition:</b>	<b>OCAN Lead:*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Staff Worker Name:*</b> <b>Staff Worker Phone Number:*</b> <b>Ext:</b> <b>Organization LHIN:*</b> <b>Organization Name:*</b> <b>Organization Number:*</b> <b>Program Name:*</b> <b>Program Number:*</b> <b>Functional Centre Name:*</b> <b>Functional Centre Number:*</b> <b>Service Delivery LHIN:*</b> <b>Referral Source:*</b> <b>Request for Service Date (YYYY-MM-DD):</b> <b>Service Decision Date (YYYY-MM-DD):</b> <b>Accepted:</b> <b>Service Initiation Date (YYYY-MM-DD):</b> <b>Exit Date (YYYY-MM-DD):</b> <b>Exit Disposition:</b>
<b>5. Family Doctor Information</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None available <input type="checkbox"/> Consumer declined to answer <input type="checkbox"/> Unknown	
Name: Address: Phone Number: City: Ext: Province: Email Address: Postal Code:	
Last seen:	
<b>6. Psychiatrist Information</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None available <input type="checkbox"/> Consumer declined to answer <input type="checkbox"/> Unknown	
Name: Address: Phone Number: City: Ext: Province: Email Address: Postal Code:	
Last seen:	
<b>7. Other Contact</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Consumer declined to answer <input type="checkbox"/> Unknown	
Contact Type:	
Name: Address: Phone Number: City: Ext: Province:	

\* Mandatory fields

Email Address:	Postal Code:			
Last seen:				
<b>Other Contact</b>				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Consumer declined to answer	<input type="checkbox"/> Unknown	
Contact Type:				
Name:	Address:			
Phone Number:	City:			
Ext:	Province:			
Email Address:	Postal Code:			
Last seen:				
<b>8. Other Agency</b>				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Consumer declined to answer	<input type="checkbox"/> Unknown	
Name:	Address:			
Phone Number:	City:			
Ext:	Province:			
Email Address:	Postal Code:			
Last seen:				
<b>9. Consumer Capacity (select all that apply)</b>				
9a. Power of Attorney for Personal Care:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Consumer declined to answer	<input type="checkbox"/> Unknown
Power of Attorney or SDM Name:				
Address:				
Phone Number:	Ext:			
9b. Power of Attorney for Property	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Consumer declined to answer	<input type="checkbox"/> Unknown
Power of Attorney:				
Address:				
Phone Number:	Ext:			
9c. Guardian	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Consumer declined to answer	<input type="checkbox"/> Unknown
Name:				
Address:				
Phone Number:	Ext:			
9d. Areas of concern				
Finance/property:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Treatment decisions:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>10. Age in years for onset of mental illness:</b>	<input type="checkbox"/> Estimate	<input type="checkbox"/> Consumer declined to answer	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
<b>11. Age of first psychiatric hospitalization:</b>	<input type="checkbox"/> Estimate	<input type="checkbox"/> Consumer declined to answer	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
<b>12. Date when consumer first entered your organization (YYYY-MM):</b>	<input type="checkbox"/> Estimate	<input type="checkbox"/> Consumer declined to answer	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
<b>13. What culture do you (consumer) identify with?</b>				
<b>14. Aboriginal Origin (select one)*</b>				
<input type="checkbox"/> Aboriginal	<input type="checkbox"/> Non-aboriginal	<input type="checkbox"/> Consumer declined to answer	<input type="checkbox"/> Unknown	
<b>15. Citizenship Status (select one)</b>				
<input type="checkbox"/> Canadian citizen	<input type="checkbox"/> Temporary resident	<input type="checkbox"/> Consumer declined to answer		

\* Mandatory fields

<input type="checkbox"/> Permanent resident	<input type="checkbox"/> Refugee	<input type="checkbox"/> Unknown
<b>16. Length of time lived in Canada (number of years/months):</b>		
<b>17. Service recipient preferred language:*</b>		
<b>18. Language of service provision:*</b>		
<b>19. Do you currently have any legal issues? (select one)*</b>		
<input type="checkbox"/> Civil	<input type="checkbox"/> Criminal	<input type="checkbox"/> None
		<input type="checkbox"/> Consumer declined to answer
<input type="checkbox"/> Unknown		
<b>20. Current Legal Status (select all that apply)</b>		
<p><b>Pre-Charge</b></p> <p><input type="checkbox"/> Pre-charge diversion</p> <p><input type="checkbox"/> Court diversion program</p> <p><b>Pre-Trial</b></p> <p><input type="checkbox"/> Awaiting fitness assessment</p> <p><input type="checkbox"/> Awaiting trial <i>(with or without bail)</i></p> <p><input type="checkbox"/> Awaiting criminal responsibility assessment (ncr)</p> <p><input type="checkbox"/> In community on own recognizance</p> <p><input type="checkbox"/> Unfit to stand trial</p> <p><b>Custody Status</b></p> <p><input type="checkbox"/> ORB detained – community access</p> <p><input type="checkbox"/> ORB conditional discharge</p> <p><input type="checkbox"/> On parole</p> <p><input type="checkbox"/> On probation</p>	<p><b>Outcomes</b></p> <p><input type="checkbox"/> Charges withdrawn</p> <p><input type="checkbox"/> Stay of proceedings</p> <p><input type="checkbox"/> Awaiting sentence</p> <p><input type="checkbox"/> NCR</p> <p><input type="checkbox"/> Conditional discharge</p> <p><input type="checkbox"/> Conditional sentence</p> <p><input type="checkbox"/> Restraining order</p> <p><input type="checkbox"/> Peace bond</p> <p><input type="checkbox"/> Suspended sentence</p> <p><b>Other</b></p> <p><input type="checkbox"/> No legal problem <i>(includes absolute discharge and time served – end of custody)</i></p> <p><input type="checkbox"/> Consumer declined to answer</p> <p><input type="checkbox"/> Unknown</p>	
<b>21. Where do you live? (select one)*</b>		
<p><input type="checkbox"/> Approved homes &amp; homes for special care</p> <p><input type="checkbox"/> Correctional/probation facility</p> <p><input type="checkbox"/> Domicillary hostel</p> <p><input type="checkbox"/> General hospital</p> <p><input type="checkbox"/> Psychiatric hospital</p> <p><input type="checkbox"/> Other specialty hospital</p> <p><input type="checkbox"/> No fixed address</p> <p><input type="checkbox"/> Hostel/shelter</p> <p><input type="checkbox"/> Long term care facility/nursing home</p> <p><input type="checkbox"/> Municipal non-profit housing</p>	<p><input type="checkbox"/> Private non-profit housing</p> <p><input type="checkbox"/> Private house/Apt. – SR owned/market rent</p> <p><input type="checkbox"/> Private house/Apt. – other/subsidized</p> <p><input type="checkbox"/> Retirement home/senior's residence</p> <p><input type="checkbox"/> Rooming/boarding house</p> <p><input type="checkbox"/> Supportive housing – congregate living</p> <p><input type="checkbox"/> Supportive housing – assisted living</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Consumer declined to answer</p> <p><input type="checkbox"/> Unknown</p>	
<b>22. Do you receive any support? (select one)*</b>		
<input type="checkbox"/> Independent	<input type="checkbox"/> Supervised non-facility	<input type="checkbox"/> Consumer declined to answer
<input type="checkbox"/> Assisted/supported	<input type="checkbox"/> Supervised facility	<input type="checkbox"/> Unknown
<b>23. Do you live with anyone? (select one)*</b>		
<input type="checkbox"/> Self	<input type="checkbox"/> Children	<input type="checkbox"/> Non-relatives
<input type="checkbox"/> Spouse/partner	<input type="checkbox"/> Parents	<input type="checkbox"/> Consumer declined to answer
<input type="checkbox"/> Spouse/partner and others	<input type="checkbox"/> Relatives	<input type="checkbox"/> Unknown
<b>24. What is your current employment status? (select one)*</b>		
<input type="checkbox"/> Independent/competitive	<input type="checkbox"/> Non-paid work experience	<input type="checkbox"/> Consumer declined to answer
<input type="checkbox"/> Assisted/supportive	<input type="checkbox"/> No employment – other activity	<input type="checkbox"/> Unknown

\* Mandatory fields

- |   |  |
|---|--|
| <input type="checkbox"/> Alternative businesses | <input type="checkbox"/> Casual/sporadic           |
| <input type="checkbox"/> Sheltered workshop     | <input type="checkbox"/> No employment of any kind |

**25. Are you currently in school? (select one)\***

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Not in school                 | <input type="checkbox"/> Vocational/training centre | <input type="checkbox"/> Other _____                 |
| <input type="checkbox"/> Elementary/junior high school | <input type="checkbox"/> Adult education            | <input type="checkbox"/> Consumer declined to answer |
| <input type="checkbox"/> Secondary/high school         | <input type="checkbox"/> Community college          | <input type="checkbox"/> Unknown                     |
| <input type="checkbox"/> Trade school                  | <input type="checkbox"/> University                 |  |

**26. Psychiatric History****26a. Have you been hospitalized due to your mental health during the past two years? (select one)\***

- |                              |                             |  |                                  |
|------------------------------|-----------------------------|--|----------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Consumer declined to answer | <input type="checkbox"/> Unknown |
|------------------------------|-----------------------------|--|----------------------------------|

**26b. 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*

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

- |                               |                                |  |
|-------------------------------|--------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> 2 - 5 | <input type="checkbox"/> Consumer declined to answer |
| <input type="checkbox"/> 1    | <input type="checkbox"/> > 6   | <input type="checkbox"/> Unknown                     |

**28. Community Treatment Order:\***

- |                                     |                                 |  |                                  |
|-------------------------------------|---------------------------------|--|----------------------------------|
| <input type="checkbox"/> Issued CTO | <input type="checkbox"/> No CTO | <input type="checkbox"/> Consumer declined to answer | <input type="checkbox"/> Unknown |
|-------------------------------------|---------------------------------|--|----------------------------------|

**29. Diagnostic Categories (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.*

- |  |  |
|--|--|
| <input type="checkbox"/> Adjustment disorders                                    | <input type="checkbox"/> Mood disorder                               |
| <input type="checkbox"/> Anxiety disorder  | <input type="checkbox"/> Personality disorders                       |
| <input type="checkbox"/> Delirium, dementia, and amnesic and cognitive disorders | <input type="checkbox"/> Schizophrenia and other psychotic disorders |
| <input type="checkbox"/> Developmental handicap                                  | <input type="checkbox"/> Sexual and gender identity disorders        |
| <input type="checkbox"/> Disorder of childhood/adolescence                       | <input type="checkbox"/> Sleep disorders                             |
| <input type="checkbox"/> Dissociative disorders                                  | <input type="checkbox"/> Somatoform disorders                        |
| <input type="checkbox"/> Eating disorders  | <input type="checkbox"/> Substance related disorders                 |
| <input type="checkbox"/> Factitious disorders                                    | <input type="checkbox"/> Intellectual disability or impairment       |
| <input type="checkbox"/> Impulse control disorders not elsewhere classified      | <input type="checkbox"/> Consumer declined to answer                 |
| <input type="checkbox"/> Mental disorders due to general medical conditions      | <input type="checkbox"/> Unknown                                     |

**30. Other Illness Information (select all that apply)**

- |  |  |
|--|--|
| <input type="checkbox"/> Concurrent disorder (substance abuse)     | <input type="checkbox"/> Other chronic illnesses     |
| <input type="checkbox"/> Dual diagnosis (developmental disability) | <input type="checkbox"/> Other physical disabilities |

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> No formal schooling                | <input type="checkbox"/> Some secondary/high school | <input type="checkbox"/> College/university          |
| <input type="checkbox"/> Some elementary/junior high school | <input type="checkbox"/> Secondary/high school      | <input type="checkbox"/> Consumer declined to answer |
| <input type="checkbox"/> Elementary/junior high school      | <input type="checkbox"/> Some college/university    | <input type="checkbox"/> Unknown                     |

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

\* Mandatory fields

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Employment           | <input type="checkbox"/> Social assistance     | <input type="checkbox"/> Other _____                 |
| <input type="checkbox"/> Employment insurance | <input type="checkbox"/> Disability assistance | <input type="checkbox"/> Consumer declined to answer |
| <input type="checkbox"/> Pension              | <input type="checkbox"/> Family                | <input type="checkbox"/> Unknown                     |
| <input type="checkbox"/> ODSP                 | <input type="checkbox"/> No source of income   |  |

**33. Presenting Issues\***

- |   |   |
|---|---|
| <input type="checkbox"/> Activities of daily living         | <input type="checkbox"/> Problems with addictions                   |
| <input type="checkbox"/> Attempted suicide                  | <input type="checkbox"/> Problems with relationships                |
| <input type="checkbox"/> Educational                        | <input type="checkbox"/> Problems with substance abuse              |
| <input type="checkbox"/> Financial                          | <input type="checkbox"/> Sexual abuse                               |
| <input type="checkbox"/> Housing                            | <input type="checkbox"/> Specific symptom of serious mental illness |
| <input type="checkbox"/> Legal                              | <input type="checkbox"/> Threat to others                           |
| <input type="checkbox"/> Occupational/employment/vocational | <input type="checkbox"/> Threat to self                             |
| <input type="checkbox"/> Physical abuse                     | <input type="checkbox"/> Other _____                                |

**34. Comments:**

**Completion Date (YYYY-MM-DD)\*:** \_\_\_\_\_