Ontario Common Assessment of Need (OCAN)

Community Mental Health Common Assessment Project

Full OCAN 2.0

Revision 2.0.5

CCIM Community Care Information Management
ACCESS TO INFORMATION

OCAN Consumer Self-Assessment

Welcome to this opportunity to speak with your own voice

This agency is using OCAN, which helps ensure that your views are a standard and formal part of your discussions with your health worker. It is comprised of two main parts: your consumer self-assessment and the staff worker assessment questions. We invite you to use this self-assessment to start the conversation with your worker. Your worker will then complete the staff part of OCAN. You have the option to participate in both parts, which will also provide a good place for you to begin your discussions with your worker.

Why we would like you to take this opportunity:

- You won't have to answer more questions every time you deal with another agency because one common set of questions will eventually be used by all 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 you and your worker decide 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 you and your worker can develop a plan 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 your worker, family, friends, etc. You also have the option to answer some or all of the questions.

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

INSTRUCTIONS:

When you have completed this assessment, your worker will have a conversation with you about your needs.

- Please let your worker know if you have completed a Common Assessment in the last six months.
- Please read the pamphlet provided on how your information will be used.
- Please ask about any questions you don't understand.

Please ✓ tick one box in each row (24 in total) using the following key:

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
1.	**Accommodation**	☐	☐	☐	☐
	What kind of place do you live in? **Comments**				
2.	**Food**	☐	☐	☐	☐
	Do you get enough to eat? **Comments**				
3.	**Looking After the Home**	☐	☐	☐	☐
	Are you able to look after your home? **Comments**				
4.	**Self-Care**	☐	☐	☐	☐
	Do you have problems keeping clean and tidy? **Comments**				
5.	**Daytime Activities**	☐	☐	☐	☐
	How do you spend your day? **Comments**				
6.	**Physical Health**	☐	☐	☐	☐
	How well do you feel physically? **Comments**				

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.	**Psychotic Symptoms**	☐	☐	☐	☐
	Do you ever hear voices or have problems with your thoughts? **Comments**				
8.	**Information on Condition and Treatment**	☐	☐	☐	☐
	Have you been given clear information about your medication? **Comments**				
9.	**Psychological Distress**	☐	☐	☐	☐
	Have you recently felt very sad or low? **Comments**				
10.	**Safety to Self**	☐	☐	☐	☐
	Do you ever have thoughts of harming yourself? **Comments**				
11.	**Safety to Others**	☐	☐	☐	☐
	Do you think you could be a danger to other people's safety? **Comments**				
12.	**Alcohol**	☐	☐	☐	☐
	Does drinking cause you any problems? **Comments**				
13.	**Drugs**	☐	☐	☐	☐
	Do you take any drugs that aren't prescribed? **Comments**				
14.	**Other Addictions**	☐	☐	☐	☐
	Do you have any other addictions – such as gambling? **Comments**				
15.	**Company**	☐	☐	☐	☐
	Are you happy with your social life? **Comments**				

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**
16.	**Intimate Relationships**	☐	☐	☐	☐
	Do you have a partner? **Comments**				
17.	**Sexual Expression**	☐	☐	☐	☐
	How is your sex life? **Comments**				
18.	**Child Care**	☐	☐	☐	☐
	Do you have any children under 18? **Comments**				
19.	**Other Dependents**	☐	☐	☐	☐
	Do you have any dependents other than children under 18, such as an elderly parent or beloved pet? **Comments**				
20.	**Basic Education**	☐	☐	☐	☐
	Any difficulty in reading, writing or understanding English? **Comments**				
21.	**Telephone**	☐	☐	☐	☐
	Do you know how to use a telephone? **Comments**				
22.	**Transport**	☐	☐	☐	☐
	How do you find using the bus, streetcar or train? **Comments**				
23.	**Money**	☐	☐	☐	☐
	How do you find budgeting your money? **Comments**				
24.	**Benefits**	☐	☐	☐	☐
	Are you getting all the money you are entitled to? **Comments**				

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?

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 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 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 the 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.

This is the Full OCAN which includes:

- the Consumer Self-assessment,
- the Staff Assessment and
- the Consumer Information Summary and Service Use. This section contains all factual information from OCAN such as name, age, gender and other Common Data Set (CDS) elements that community mental health functional centres complete.

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
☐ Reassessment
☐ (Prior to) Discharge
☐ Significant change
☐ Review
☐ Re-key
☐ Other (e.g., consumer request)
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 ☐ Unknown
Health Card Number:
Version Code:
Issuing Territory:
Service Recipient Location (county, district, municipality):*
LHIN Consumer Resides in:*

4b. Gender (select one)* ☐ Male ☐ Female ☐ Other ☐ Consumer declined to answer ☐ Unknown

4c. Marital Status (select one)

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

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:***	

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

**** Mandatory fields***

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:**

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 ☐ Consumer declined to answer ☐ Unknown

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

Last seen:

7. Psychiatrist Information

☐ Yes ☐ No ☐ None available ☐ Consumer declined to answer ☐ Unknown

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

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

**** Mandatory fields***

Last seen:

8. Other Contact

☐ Yes ☐ No ☐ Consumer declined to answer ☐ Unknown

Contact Type:

Name: Address:

Phone Number: City:

Ext: Province:

Email Address: Postal Code:

Last seen:

Other Contact

☐ Yes ☐ No ☐ Consumer declined to answer ☐ Unknown

Contact Type:

Name: Address:

Phone Number: City:

Ext: Province:

Email Address: Postal Code:

Last seen:

9. Other Agency

☐ Yes ☐ No ☐ Consumer declined to answer ☐ Unknown

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 ☐ Consumer declined to answer ☐ Unknown

Power of Attorney or SDM Name:

Address:

Phone Number: Ext:

10b. Power of Attorney for Property ☐ Yes ☐ No ☐ Consumer declined to answer ☐ Unknown

Power of Attorney:

Address:

Phone Number: Ext:

10c. Guardian ☐ Yes ☐ No ☐ Consumer declined to answer ☐ Unknown

Name:

Address:

Phone Number: Ext:

10d. Areas of Concern

Finance/property: ☐ Yes ☐ No ☐ Unknown

Treatment decisions: ☐ Yes ☐ No ☐ Unknown

11. Age in years for onset of mental illness: ☐ Estimate ☐ Consumer declined to answer ☐ Unknown ☐ N/A

12. Age of first psychiatric hospitalization: ☐ Estimate ☐ Consumer declined to answer ☐ Unknown ☐ N/A

13. Date when consumer first entered your organization (YYYY-MM): ☐ Estimate ☐ Consumer declined to answer ☐ Unknown ☐ N/A

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

**** Mandatory fields***

14. What culture do you (consumer) identify with?

15. Aboriginal Origin (select one)*

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

16. Citizenship Status (select one)

☐ Canadian citizen ☐ Temporary resident ☐ Consumer declined to answer

☐ Permanent resident ☐ Refugee ☐ Unknown

17. Length of time lived in Canada (number of years/months):

18. 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 _____

☐ Consumer declined to answer

☐ Unknown

19. Can you tell me about your immigration experience?

20. Experience of Discrimination (select all that apply)

☐ Disability ☐ Mental illness ☐ Other _____

☐ Ethnicity ☐ Race ☐ Consumer declined to answer

☐ Gender ☐ Religion ☐ Unknown

☐ Immigration ☐ Sexual Orientation

21. Service recipient preferred language:*

22. Language of service provision:*

23. Do you currently have any legal issues? (select one)*

☐ Civil ☐ Criminal ☐ None ☐ Consumer Declined to Answer ☐ Unknown

24. 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

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)*

☐ Consumer declined to answer

☐ Unknown

***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 = Unknown

**** Mandatory fields***

25. 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 = Unknown

**** Mandatory fields***

Staff Assessment

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 (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 _____
- ☐ Consumer declined to answer
- ☐ Unknown

Do you receive any support? (select one)*

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

Do you live with anyone? (select one)*

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

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:	

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 = Unknown

**** Mandatory fields***

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

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 (YYYY-MM-DD):

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 (YYYY-MM-DD):

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 (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 = Unknown

**** Mandatory fields***

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
☐ Consumer declined to answer
☐ Unknown

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_____
☐ Consumer declined to answer
☐ Unknown

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_____
☐ Consumer declined to answer

Comments:

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 (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
Specify _____
☐ Breathing problems
☐ Cancer
☐ Cirrhosis
☐ Communicable disease
☐ Eating disorder
☐ Epilepsy
☐ Hearing impairment
☐ Heart condition
☐ Hepatitis
☐ A ☐ B ☐ C ☐ D
☐ HIV
☐ High blood pressure
☐ High cholesterol
☐ Osteoporosis
☐ Pregnancy
☐ Seizure
☐ Sexually Transmitted Infection (STI)
☐ Skin conditions
☐ Sleep problems (e.g., insomnia)
☐ Stroke
☐ Thyroid
☐ Vision impairment

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

**** Mandatory fields***

☐ Diabetes		☐ Intellectual disability	☐ Other _____
☐ Type 1	☐ Type 3	☐ Low blood pressure	☐ Consumer declined to answer
☐ Type 2	☐ Other	☐ Obesity	☐ Unknown

Comments:

Do you have concerns about your physical health? (select one)

☐ Yes ☐ No ☐ Consumer declined to answer ☐ Unknown

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

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

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	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:

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 (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 = Unknown

**** Mandatory fields***

Psychiatric History

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

☐ Yes ☐ No ☐ Consumer declined to answer ☐ Unknown

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 ☐ Consumer declined to answer

☐ 1 ☐ > 6 ☐ Unknown

Community Treatment Order:*

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

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 *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 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 = Unknown

**** Mandatory fields***

Comments:

Action(s): By Whom:

Review Date (YYYY-MM-DD):

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.

- ☐ Adjustment disorders
- ☐ Anxiety disorder
- ☐ Delirium, dementia, and amnestic and cognitive disorders
- ☐ Developmental handicap
- ☐ 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
- ☐ Intellectual disability or impairment
- ☐ Consumer declined to answer
- ☐ Unknown

Other Illness Information (select all that apply)

- ☐ Concurrent disorder (substance abuse)
- ☐ Dual diagnosis (developmental disability)
- ☐ Other chronic illnesses
- ☐ Other 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 (YYYY-MM-DD):

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:

***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 = Unknown

**** Mandatory fields***

Action(s): By Whom:

Review Date (YYYY-MM-DD):

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

☐ Yes ☐ No ☐ Consumer declined to answer ☐ Unknown

Do you currently have suicidal thoughts? (select one)

☐ Yes ☐ No ☐ Consumer declined to answer ☐ Unknown

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

☐ Yes ☐ No ☐ Consumer declined to answer ☐ Unknown

Risks (select all that apply)

☐ Abuse/neglect ☐ Exploitation risk

☐ Accidental self-harm ☐ Other _____

☐ Deliberate self-harm

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 (YYYY-MM-DD):

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 (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

How has drinking had an impact on your life?

***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 = Unknown

**** Mandatory fields***

13. Drugs	Staff Rating
Do you take drugs that aren't prescribed? Are there any drugs you would find hard to stop taking?	
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	☐	☐
Solvents	☐	☐
Other	☐	☐
Has the substance been injected?	☐	☐

Indicate the Stage of Change Consumer 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	Staff Rating
Do you have an addiction? Is your addiction a problem?	
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 _____

***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 = Unknown

**** Mandatory fields***

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

☐ Precontemplation ☐ Contemplation ☐ Action ☐ Maintenance ☐ Relapse prevention

How has the addiction had an impact on your life?

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

Have there been any changes to your social patterns recently? (select one)

☐ Yes ☐ No ☐ Consumer declined to answer ☐ Unknown

16. Intimate Relationships	Staff Rating
Do you have a partner? Do you have problems in your partnership/marriage?	
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 (YYYY-MM-DD):

17. Sexual Expression	Staff Rating
How is your sex life?	
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):

***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 = Unknown

**** Mandatory fields***

18. Child Care	Staff Rating
Do you have any children under 18? Do you have any difficulty in looking after them?	
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
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?	
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 (YYYY-MM-DD):	

20. Basic Education	Staff Rating
Do you have difficulty in reading, writing, speaking or understanding English? Any other languages?	
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	☐ Consumer declined to answer
☐ Elementary/junior high school	☐ Some college/university	☐ Unknown

***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 = Unknown

**** Mandatory fields***

21. Telephone	Staff Rating
Do you know how to use a telephone? Is it easy to find one that you can use?	
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
Do you have access to transportation? Do you have access to other affordable transportation methods?	
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 (YYYY-MM-DD):	

23. Money	Staff Rating
How do you find budgeting your money? Do you manage to pay your bills?	
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	☐ Consumer Declined to Answer
☐ Pension	☐ Family	☐ Unknown
☐ ODSP	☐ No Source of Income	

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 = Unknown

**** Mandatory fields***

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 (YYYY-MM-DD):

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*

- ☐ 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)

***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 = Unknown

**** Mandatory fields***

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 = Unknown

**** Mandatory fields***