

Ontario Common Assessment of Need (OCAN)

Community Mental Health Common Assessment Project



Core OCAN 2.0

Revision 2.0.5

CORE OCAN

➔ Using CORE OCAN

This agency is using the Core OCAN which comprises only the Consumer Information Summary and Service Use and not the Consumer Self-Assessment or Staff Assessment parts of OCAN. The Core OCAN captures 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 assessment. 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 | <input type="checkbox"/> Review |
| <input type="checkbox"/> Reassessment | <input type="checkbox"/> Re-key |
| <input type="checkbox"/> (Prior to) Discharge | <input type="checkbox"/> Other (e.g., consumer request) _____ |
| <input type="checkbox"/> Significant change | |

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:
Service Initiation Date (YYYY-MM-DD):	Service Initiation Date (YYYY-MM-DD):

* Mandatory fields

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:* <input type="checkbox"/> Yes <input type="checkbox"/> No Staff Worker Name:* Staff Worker Phone Number:* Ext: Organization LHIN:* Organization Name:* Organization Number:* Program Name:* Program Number:* Functional Centre Name:* Functional Centre Number:* Service Delivery LHIN:* Referral Source:* Request for Service Date (YYYY-MM-DD): Service Decision Date (YYYY-MM-DD): Accepted: Service Initiation Date (YYYY-MM-DD): Exit Date (YYYY-MM-DD): Exit Disposition:	OCAN Lead:* <input type="checkbox"/> Yes <input type="checkbox"/> No Staff Worker Name:* Staff Worker Phone Number:* Ext: Organization LHIN:* Organization Name:* Organization Number:* Program Name:* Program Number:* Functional Centre Name:* Functional Centre Number:* Service Delivery LHIN:* Referral Source:* Request for Service Date (YYYY-MM-DD): Service Decision Date (YYYY-MM-DD): Accepted: Service Initiation Date (YYYY-MM-DD): Exit Date (YYYY-MM-DD): Exit Disposition:
5. Family Doctor Information	
<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:	
6. Psychiatrist Information	
<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:	
7. Other Contact	
<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:					
Other Contact					
<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:					
8. Other Agency					
<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:					
9. Consumer Capacity (select all that apply)					
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	
10. Age in years for onset of mental illness:		<input type="checkbox"/> Estimate	<input type="checkbox"/> Consumer declined to answer	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
11. Age of first psychiatric hospitalization:		<input type="checkbox"/> Estimate	<input type="checkbox"/> Consumer declined to answer	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
12. Date when consumer first entered your organization (YYYY-MM):		<input type="checkbox"/> Estimate	<input type="checkbox"/> Consumer declined to answer	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
13. What culture do you (consumer) identify with?					
14. Aboriginal Origin (select one)*					
<input type="checkbox"/> Aboriginal	<input type="checkbox"/> Non-aboriginal	<input type="checkbox"/> Consumer declined to answer	<input type="checkbox"/> Unknown		
15. Citizenship Status (select one)					
<input type="checkbox"/> Canadian citizen	<input type="checkbox"/> Temporary resident	<input type="checkbox"/> Consumer declined to answer			
<input type="checkbox"/> Permanent resident	<input type="checkbox"/> Refugee	<input type="checkbox"/> Unknown			

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

- Sheltered workshop No employment of any kind

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

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

26. Psychiatric History

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

- Yes No Consumer declined to answer 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?*

- None 2 - 5 Consumer declined to answer
 1 > 6 Unknown

28. Community Treatment Order:*

- Issued CTO No CTO Consumer declined to answer 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)

- Concurrent disorder (substance abuse) Other chronic illnesses
 Dual diagnosis (developmental disability) Other physical disabilities

31. 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

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

- Employment Social assistance Other _____

- Employment insurance
- Pension
- ODSP

- Disability assistance
- Family
- No source of income

- Consumer declined to answer
- Unknown

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)*: _____