Ontario Common Assessment of Need (OCAN)

Community Mental Health Common Assessment Project

Core OCAN 3.0

CCIM Community Care Information Management

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.

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

Consumer Information Summary

1. OCAN Lead Assessment

OCAN completed by OCAN Lead?* ☐ Yes ☐ No

2. Reason for OCAN (select one)*

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

3. Consumer Information

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

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

3b. What is your gender? (select one)* ☐ Male ☐ Female ☐ Intersex ☐ Trans-Female to Male
☐ Trans-Male to Female ☐ Prefer not to answer ☐ Do not know ☐ Other (please specify) _____

3c. Marital Status (select one)*

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

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

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

**** Mandatory fields***

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:**

5. Family Doctor Information

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

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

Last seen:

6. Psychiatrist Information

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

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

Last seen:

7. Other Contact

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

Contact Type:

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

Last seen:

**** Mandatory fields***

Other Contact

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

Contact Type:

Name: Address:

Phone Number: City:

Ext: Province:

Email Address: Postal Code:

Last seen:

8. Other Agency

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

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

Power of Attorney or SDM Name:

Address:

Phone Number: Ext:

9b. Power of Attorney for Property ☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

Power of Attorney:

Address:

Phone Number: Ext:

9c. Guardian ☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

Name:

Address:

Phone Number: Ext:

9d. Areas of concern

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

Treatment decisions: ☐ Yes ☐ No ☐ Do not know

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

**** Mandatory fields***

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

- ☐ Asian - East (e.g. Chinese, Japanese, Korean)
- ☐ Asian - South (e.g. Indian, Pakistani, Sri Lankan)
- ☐ Asian - South East (e.g. Malaysian, Filipino, Vietnamese)
- ☐ Black - African (e.g. Ghanaian, Kenyan, Somali)
- ☐ Black - Caribbean (e.g. Barbadian, Jamaican)
- ☐ Black - North American (e.g. Canadian, American)
- ☐ First Nations
- ☐ Indian - Caribbean (e.g. Guyanese with origins in India)
- ☐ Indigenous/Aboriginal - not included elsewhere
- ☐ Inuit
- ☐ Latin American (e.g. Argentinean, Chilean, Salvadoran)
- ☐ Metis
- ☐ Middle Eastern (e.g. Egyptian, Iranian, Lebanese)
- ☐ White - European (e.g. English, Italian, Portuguese, Russian)
- ☐ White - North American (e.g. Canadian, American)
- ☐ Mixed heritage (e.g. Black - African & White – North American)
  Please specify: _____
- ☐ Other _____
- ☐ Prefer not to answer
- ☐ Do not know

14. What is your Sexual Orientation? (Select One)*

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

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

15. Citizenship Status (select one)

☐ Canadian citizen ☐ Temporary resident ☐ Prefer not to answer

☐ Permanent resident ☐ Refugee ☐ Do not know

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

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

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

18. Language of service provision*

19. What is your mother tongue? (select one)*

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

☐ English ☐ French

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

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

22. Comment on legal issues:

23. Current Legal Status (select all that apply)*

Pre-Charge

- ☐ Pre-charge diversion
- ☐ Court diversion program

Pre-Trial

- ☐ Awaiting fitness assessment
- ☐ Awaiting trial *(with or without bail)*
- ☐ Awaiting criminal responsibility assessment (NCR)
- ☐ In community on own recognizance
- ☐ Unfit to stand trial

Outcomes

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

**** Mandatory fields***

☐ Suspended sentence

Custody Status

☐ Incarceration

☐ ORB detained – community access

☐ ORB conditional discharge

Other

☐ On parole

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

☐ On probation

☐ Prefer not to answer

☐ Do not know

24. Where do you live? (select one)*

☐ Approved homes & homes for special care

☐ Correctional/probation facility

☐ Domicillary hostel

☐ General hospital

☐ Psychiatric hospital

☐ Other specialty hospital

☐ No fixed address

☐ Hostel/shelter

☐ Long term care facility/nursing home

☐ Municipal non-profit housing

☐ Private non-profit housing

☐ Private house/Apt. – SR owned/market rent

☐ Private house/Apt. – other/subsidized

☐ Retirement home/senior's residence

☐ Rooming/boarding house

☐ Supportive housing – congregate living

☐ Supportive housing – assisted living

☐ Other _____

☐ Prefer not to answer

☐ Do not know

25. Do you receive any support? (select one)*

☐ Independent

☐ Assisted/supported

☐ Supervised non-facility

☐ Supervised facility

☐ Prefer not to answer

☐ Do not know

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

☐ No-on my own

☐ Spouse/partner

☐ Other

☐ Children

☐ Parents

☐ Prefer not to answer

☐ Non-relatives

☐ Relatives

☐ Do not know

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

☐ Independent/competitive

☐ Assisted/supportive

☐ Alternative businesses

☐ Sheltered workshop

☐ Non-paid work experience

☐ No employment – other activity

☐ Casual/sporadic

☐ No employment – of any kind

☐ Prefer not to answer

☐ Do not know

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

☐ Not in school

☐ Elementary/junior high school

☐ Secondary/high school

☐ Trade school

☐ Vocational/training centre

☐ Adult education

☐ Community college

☐ University

☐ Other_____

☐ Prefer not to answer

☐ Do not know

29. Psychiatric History

29a. Have you been hospitalized due to your mental health? (select one)*

If Initial OCAN, during the past two years OR if Reassessment, since the last OCAN

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

29b. 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

**** Mandatory fields***

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

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

☐ None ☐ 2 - 5 ☐ Prefer not to answer

☐ 1 ☐ >6 ☐ Do not know

31. Community Treatment Orders:*

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

32. Diagnostic Categories (select all that apply)* **Source of Diagnosis (select one):**

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

☐ Not Applicable

☐ Prefer not to answer

☐ Do not know

33. Do you have any of the following disabilities? (select all that apply)*

☐ Chronic Illness

☐ Drug or Alcohol Dependence

☐ Mental Illness

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

☐ Prefer not to answer

☐ Do not know

☐ Development Disability

☐ Learning Disability

☐ Physical Disability

☐ None

☐ Other (Please specify): _____

**** Mandatory fields***

34. 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
☐ Prefer not to answer
☐ Do not know

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

☐ Employment
☐ Employment insurance
☐ Pension
☐ ODSP
☐ Social assistance
☐ Disability assistance
☐ Family
☐ No source of income
☐ Other _____
☐ Prefer not to answer
☐ Do not know

36. What is your total family income before taxes last year? (select one)*

☐ $0 – $19,999
☐ $20,000 – $29,999
☐ $30,000 - $59,999
☐ $60,000 - $ 89,999
☐ $90,000 - $119,999
☐ $120,000 - $149,999
☐ $150,000 or more
☐ Prefer not to answer
☐ Do not know

37. How many people does this income support?*

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

38. Presenting Issues (select all that apply)*

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

39. General Comments:

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

**** Mandatory fields***