

Core OCAN

Ontario Common Assessment of Need (OCAN)

Software Version 3.0 (August, 2018)

Form Version 3.0 (updated May, 2020)

Core OCAN

Using Core OCAN

This agency is using the Core OCAN which comprises only the Consumer Information Summary and Mental Health Functional Centre Use section components and not the Consumer Self-Assessment or Staff Assessment components 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:	Date of Birth (YYYY-MM-DD):* <input type="checkbox"/> Estimate <input type="checkbox"/> Do not know
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:	Email Address:
Postal Code:	
Phone Number: Ext:	

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:* <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):
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
<p>OCAN Lead:* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Staff Worker Name:*</p> <p>Staff Worker Phone Number:* Ext:</p> <p>Organization LHIN:*</p> <p>Organization Name:*</p> <p>Organization Number:*</p> <p>Program Name:*</p> <p>Program Number:*</p> <p>Functional Centre Name:*</p> <p>Functional Centre Number:*</p> <p>Service Delivery LHIN:*</p> <p>Referral Source:*</p> <p>Request for Service Date (YYYY-MM-DD):</p> <p>Service Decision Date (YYYY-MM-DD):</p> <p>Accepted:</p> <p>Service Initiation Date (YYYY-MM-DD):</p> <p>Exit Date (YYYY-MM-DD):</p> <p>Exit Disposition:</p>	<p>OCAN Lead:* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Staff Worker Name:*</p> <p>Staff Worker Phone Number:* Ext:</p> <p>Organization LHIN:*</p> <p>Organization Name:*</p> <p>Organization Number:*</p> <p>Program Name:*</p> <p>Program Number:*</p> <p>Functional Centre Name:*</p> <p>Functional Centre Number:*</p> <p>Service Delivery LHIN:*</p> <p>Referral Source:*</p> <p>Request for Service Date (YYYY-MM-DD):</p> <p>Service Decision Date (YYYY-MM-DD):</p> <p>Accepted:</p> <p>Service Initiation Date (YYYY-MM-DD):</p> <p>Exit Date (YYYY-MM-DD):</p> <p>Exit Disposition:</p>
<p>5. Family Doctor Information</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None available <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Do not know</p>	
<p>Name:</p> <p>Phone Number:</p> <p>Ext:</p> <p>Email Address:</p>	<p>Address:</p> <p>City:</p> <p>Province:</p> <p>Postal Code:</p>
<p>Last seen:</p>	
<p>6. Psychiatrist Information</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None available <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Do not know</p>	
<p>Name:</p> <p>Phone Number:</p> <p>Ext:</p> <p>Email Address:</p>	<p>Address:</p> <p>City:</p> <p>Province:</p> <p>Postal Code:</p>
<p>Last seen:</p>	
<p>7. Other Contact</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Do not know</p>	
<p>Contact Type:</p>	
<p>Name:</p> <p>Phone Number:</p> <p>Ext:</p> <p>Email Address:</p>	<p>Address:</p> <p>City:</p> <p>Province:</p> <p>Postal Code:</p>
<p>Last seen:</p>	

Other Contact				
<input type="checkbox"/> Yes		<input type="checkbox"/> No		<input type="checkbox"/> Prefer not to answer
				<input type="checkbox"/> Do not know
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"/> Prefer not to answer
				<input type="checkbox"/> 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:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prefer not to answer
				<input type="checkbox"/> Do not know
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"/> Prefer not to answer
				<input type="checkbox"/> Do not know
Power of Attorney:				
Address:				
Phone Number:		Ext:		
9c. Guardian		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prefer not to answer
				<input type="checkbox"/> Do not know
Name:				
Address:				
Phone Number:		Ext:		
9d. Areas of concern				
Finance/property:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Do not know
Treatment decisions:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Do not know
10. Age in years for onset of mental illness:		<input type="checkbox"/> Estimate	<input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Do not know
11. Age of first psychiatric hospitalization:		<input type="checkbox"/> Estimate	<input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Do not know
12. Most recent date consumer entered your organization (YYYY-MM):		<input type="checkbox"/> Estimate	<input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Do not know
				<input type="checkbox"/> N/A

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

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

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)

- | | | |
|---|---|---|
| <input type="checkbox"/> Canadian citizen | <input type="checkbox"/> Temporary resident | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Permanent resident | <input type="checkbox"/> Refugee | <input type="checkbox"/> 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

Custody Status

- ORB detained – community access
- ORB conditional discharge
- On parole
- On probation

- Suspended sentence
- Incarceration

Other

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Independent | <input type="checkbox"/> Supervised non-facility | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Assisted/supported | <input type="checkbox"/> Supervised facility | <input type="checkbox"/> Do not know |

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

- | | | |
|---|---|--|
| <input type="checkbox"/> No-on my own | <input type="checkbox"/> Children | <input type="checkbox"/> Non-relatives |
| <input type="checkbox"/> Spouse/partner | <input type="checkbox"/> Parents | <input type="checkbox"/> Relatives |
| <input type="checkbox"/> Other | <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Do not know |

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Independent/competitive | <input type="checkbox"/> Non-paid work experience | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Assisted/supportive | <input type="checkbox"/> No employment – other activity | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> Alternative businesses | <input type="checkbox"/> Casual/sporadic | |
| <input type="checkbox"/> Sheltered workshop | <input type="checkbox"/> No employment – of any kind | |

28. 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"/> Prefer not to answer |
| <input type="checkbox"/> Secondary/high school | <input type="checkbox"/> Community college | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> Trade school | <input type="checkbox"/> University | |

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

- | | | | |
|------------------------------|-----------------------------|---|--------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> 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

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):**

- | | | | |
|--|--|--|-------------------------------|
| <input type="checkbox"/> Neurodevelopmental Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Schizophrenia Spectrum and Other Psychotic Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Bipolar and Related Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Depressive Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Anxiety Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Obsessive-Compulsive and Related Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Trauma- and Stressor-Related Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Dissociative Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Somatic Symptom and Related Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Feeding and Eating Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Elimination Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Sleep-Wake Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Sexual Dysfunctions | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Gender Dysphoria | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Disruptive, Impulse-Control, and Conduct Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Substance-Related and Addictive Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Neurocognitive Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Personality Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Paraphilic Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other Mental Disorders | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Medication-Induced Movement Disorders and Other Adverse Effects of Medication | <input type="checkbox"/> Self-reported | <input type="checkbox"/> Diagnosing Practitioner | <input type="checkbox"/> Both |
| <input type="checkbox"/> Not Applicable | | | |
| <input type="checkbox"/> Prefer not to answer | | | |
| <input type="checkbox"/> Do not know | | | |

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

- | | |
|---|--|
| <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Development Disability |
| <input type="checkbox"/> Drug or Alcohol Dependence | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Sensory Disability (i.e. hearing or vision loss) | <input type="checkbox"/> None |
| <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Other (Please specify): _____ |
| <input type="checkbox"/> Do not know | |

34. 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"/> Prefer not to answer |
| <input type="checkbox"/> Elementary/junior high school | <input type="checkbox"/> Some college/university | <input type="checkbox"/> Do not know |

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

- | | | |
|---|--|---|
| <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"/> Pension | <input type="checkbox"/> Family | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> ODSP | <input type="checkbox"/> No source of income | <input type="checkbox"/> Do not know |

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

- | | |
|---|--|
| <input type="checkbox"/> \$0 – \$19,999 | <input type="checkbox"/> \$120,000 - \$149,999 |
| <input type="checkbox"/> \$20,000 – \$29,999 | <input type="checkbox"/> \$150,000 or more |
| <input type="checkbox"/> \$30,000 - \$59,999 | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> \$60,000 - \$ 89,999 | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> \$90,000 - \$119,999 | |

37. How many people does this income support?*

- _____ person(s) Prefer not to answer Do not know

38. Presenting Issues (select all that apply)*

- | | |
|---|---|
| <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 _____ |

39. General Comments:

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