Assessment and Intervention Plan

MHR# | | | | | |

Patient ______

Instructions: **1**.Use Ink & press firmly. **2**. Use an X to indicate your choice(s).

DOB | | | (DD) | | | (MM) | | | | | (YYYY) HIN | | | | | | | | | | | | | | Gender ☐ M ☐ F

Date of First Appointment | | | (DD) | | | (MM) | | | | | (YYYY) Date of First Visit | | | (DD) | | | (MM) | | | | | (YYYY)

Instructions: **1**. **X** the appropriate box(es) relevant to this episode of care.
2 . Place an **X** on the line next to the **Problem Most Responsible for this Referral**

Psychiatric Symptoms

- ☐ Depressed Mood __
- ☐ Elevated Mood __
- ☐ Fluctuating Mood (Mood Swings) __
- ☐ Suicidal Thoughts/ Actions/ Behaviour __
- ☐ Obsessive Thoughts __
- ☐ Compulsive Behaviour __
- ☐ Phobia(s) __
- ☐ Panic Symptoms or Attacks __
- ☐ Social Anxiety __
- ☐ Other Anxiety Symptoms __
- ☐ Flashbacks/Other Post-Traumatic Stress Symptoms __
- ☐ Excessive Somatic Symptoms __
- ☐ Sleep Disturbance __
- ☐ Delusions __
- ☐ Paranoia __
- ☐ Hallucinations __
- ☐ Disorganized Thought Processes __
- ☐ Memory Impairment/Concentration __
- ☐ Confusion __
- ☐ Attention Deficit/Hyperactivity __
- ☐ Personality Problems __
- ☐ Unusual Behaviour __
- ☐ Alcohol Abuse in Self __
- ☐ Other Substance Abuse in Self __
- ☐ Gambling __
- ☐ Abnormal Eating Behaviours __
- ☐ Learning Disability __
- ☐ Developmental Delay (MR) __

Psychosocial Issues

- ☐ Marital/Common-Law /Partner Problem __
- ☐ Separation/Divorce __
- ☐ Other Relationship Issues __
- ☐ Sexual Problem __
- ☐ Self Esteem __
- ☐ Anger/Temper Control __
- ☐ Bereavement __
- ☐ Parenting Issues __
- ☐ Child Behaviour Problem __
- ☐ Other Family Problems __
- ☐ Illness in Family Member __
- ☐ Burden of Caring for Another __
- ☐ Menopause - Related Issues __
- ☐ Pre-Menstrual Symptoms __
- ☐ Pregnancy-Related Issues __
- ☐ Alcohol Abuse in Family Member __
- ☐ Past Alcohol Abuse in Self __
- ☐ Past Substance Abuse in Self __
- ☐ Lack of Social Supports/Social Isolation __
- ☐ Physical/Sexual Abuse During Childhood __
- ☐ Past Physical/Sexual Abuse (Victim) __
- ☐ Current Physical/Sexual Abuse (Partner) __
- ☐ Emotional/Verbal Abuse __
- ☐ Other Current Abuse __
- ☐ School Problems __
- ☐ Work Problems __
- ☐ Motor Vehicle Accident Issues __
- ☐ Accommodation __
- ☐ Unemployment __
- ☐ Financial Issues __
- ☐ Legal Issues __
- ☐ Other Stressful Events __
- ☐ Insurance Form/Letter to be Prepared __
- ☐ Legal Letter/Report to be Prepared __
- ☐ WSIB Issue __
- ☐ Needs Instrumental Assistance __

Medical / Physical Issues

- ☐ Chronic Pain __
- ☐ Medication Side Effects __
- ☐ Physical Symptoms Other Than Chronic Pain __
- ☐ Significant Medical/Physical Illness __ ______________________
- ☐ Difficulty Coping with Physical Illness __

Clinical Impression

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Treatment Plan (**X** all that apply)

- ☐ Assessment and Recommendations
- ☐ Supportive Therapy
- ☐ CBT
- ☐ IPT/Problem-Solving Therapy
- ☐ Psychodynamic Therapy
- ☐ Bereavement Counselling
- ☐ Other Individual Counselling
- ☐ Client Education
- ☐ Marital/Couple Counselling
- ☐ Family Counselling
- ☐ Parenting Skills
- ☐ Referral to HSO Psychiatrist
- ☐ Referral to HSO Group
- ☐ Referral to Community Program
- ☐ Referral to Community/School Counsellor or EAP
- ☐ Referral to Outpatient Psychiatry
- ☐ **CASE CLOSED**

| | | | | | | | | | | | |
(Please print name)

| | | (DD) | | | (MM) | | | | | (YYYY)
Date Completed

White copy to chart Yellow copy to program