Treatment Outcome

MHR# ☐☐☐☐☐

Patient ____________________

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

DOB ☐☐ (DD) ☐☐ (MM) ☐☐☐☐ (YYYY) HIN ☐☐☐☐☐☐☐☐☐☐ ☐☐

Total number of visits for this Episode of care ☐☐☐ (includes all visits relating to this patient's episode of care)

Date of last Scheduled Appointment ☐☐ (DD) ☐☐ (MM) ☐☐☐☐ (YYYY)

Instructions: **1**. **X** the appropriate box(es) relevant to this episode of care.

Patient Not Seen

- ☐ Patient did not follow through
- ☐ Patient no longer requires service
- ☐ Patient sought help elsewhere

During this episode of care which of the following took place? (Please X all that apply)

- ☐ Assessment & Recommendations
- ☐ Supportive Therapy
- ☐ CBT
- ☐ IPT/Problem-Solving Therapy
- ☐ Psychodynamic Therapy
- ☐ Bereavement Counselling
- ☐ Other Individual Counselling/Therapy
- ☐ Client Education
- ☐ Marital/Couple Counselling
- ☐ Family Counselling
- ☐ Parenting skills
- ☐ Other Management Strategies
- ☐ Seen by HSO Psychiatrist
- ☐ Seen by Community Counsellor, School Counsellor or EAP
- ☐ Seen in Crisis/EPT/COAST
- ☐ Referral to HSO Group
- ☐ Referral to Other Group (Non-HSO)
- ☐ Referral to Community Program
- ☐ Referral to Outpatient Psychiatry
- ☐ Patient Dropped Out of Therapy/Did Not Complete
- ☐ Psychiatric Inpatient Admission

Disposition of Patient after Treatment Completed (Please X all that apply)

- ☐ FP to continue Counselling/Support for this problem
- ☐ Referral to Community Mental Health Program
- ☐ Ongoing care being provided by Community Counsellor / School Counsellor or EAP
- ☐ New Referral to Community Counsellor / School Counsellor or EAP
- ☐ Unknown
- ☐ Referral to other Community Program
- ☐ HSO Psychiatrist to see
- ☐ HSO Group
- ☐ No further treatment required
- ☐ Moved/Changed FP

Clinical Impression

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☐☐☐☐☐☐☐☐☐☐☐☐ (Please print name)

☐☐ (DD) ☐☐ (MM) ☐☐☐☐ (YYYY) Date Completed

White copy to chart   Yellow copy to program