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| **Community Mental Health Clinical Review** | | | | | | | | | | | | |
| **Date:** | Click here to enter a date. | | | | | **Assessment Clinician:** | | | | | |  |
| **Team:** |  | | | | | | | | | | | |
| **Client:** |  | | | | | | | | **PHIN:** | |  | |
| **DOB/Age:** |  | | | | | | **Assessment Date:** | | | | Click here to enter a date. | |
| **Diagnostic Impression \*Required\*:** | | | | Choose an item. | | | | | | | | |
|  | | | | | | | | | | | | |
| **Treatment Modality:** | | | Choose an item. | | | | | | | | | |
| **Priority Rating:** | | | Choose an item. | | | | | | | | | |
| **Recommendations for Adult:**  **Full DBT - TAU with DBT Skills Group - CBT - ACT - Mindfulness -**  **Psychoeducation - Motivational Interviewing - Self-Management Skills -**  **Behavioral Activation - Medication Education - Solution Focused Therapy -**  **Skills Seekers Group - CBT Skills Group - Exposure - Grief -**  **Psychiatric Consultation - Psychology Consultation - IPT- Brief Psychodynamic -**  **Resource Counselling - Med Education - Illness Education - Relapse Prevention -**  **Trans-Diagnostic Protocol -** | | | | | | | | | | | | |
| **Recommendations for Child & Adolescent:**  **1:1 CBT - CBT Group - 1:1 DBT Skills Building - DBT Skills Group -**  **Psychiatric Consultation - ADHD Brief Protocol - Psychology Consultation -**  **Parent Coaching - Resource Counselling - Psycho Education -**  **Crisis/Safety Planning - Self Esteem Building - Recommend Family Therapy -**  **Recommend Psycho-Education Testing - Liaise with Schools - Liaise with CFS/CDS -**  **Liaise with AFM - Motivational Interviewing - Exposure & Response Prevention -**  **Anger Management Skill Building- Medication Monitoring -**  **Linkage to other resources/referral to other agency - Trans-Diagnostic Protocol -** | | | | | | | | | | | | |
| **Case Assignment Comments or Additional Considerations:**  **Add to DBT info session Wait List** | | | | | | | | | | | | |
| **Preference for Location of Treatment:** | | | | |  | | | | | | | |
| ***Discussion with Client*** *(Assessment Clinician)* | | | | | | | | *Date:* | | Click here to enter a date. | | |
| ***Client’s response* \* Required\**:*** | | | | | | | | | | | | |
| *(For clients who will be placed on a wait list for treatment only, please use the following script):*  *As mentioned to you before, treatment services will be provided by a different CMHW.  There is currently a wait to have a treatment CMHW assigned. The wait time is likely to be approximately “X” weeks, so your name will be placed on a wait list.  We are unable to provide treatment while you are on the wait list, however if you have any questions about services in the meantime, please feel free to contact Access at 1-888-310-4593.  If you require urgent services, please contact crisis services at 1-888-617-7715. As soon as a Community Mental Health Worker is available, they will contact you.* | | | | | | | | | | | | |
| *Disposition:* | |  | | | | | | | | | | |
| *Date:* | |  | | | | | | | | | | |