



64036

CMHEI - Service/ Resource Use Form - F2 Psychiatrist Visits Log

(Please print using BLOCK letters and numbers inside boxes)

SU - F2
FAM
pg 1/5

ID:

Date (mm/dd/yy): / /

Person Completing Form:

Indicate Period: Baseline Follow-up 3
 Follow-up 1 Follow-up 4
 Follow-up 2

In the **PAST 30 DAYS** did the consumer use the services of a psychiatrist?

- Yes **If yes, complete one line for each visit:**
- No **If no or unknown, go to next page.**
- Unknown

Location	Province (if not ON)	Group, individual or family therapy ?	Length of visit
<input type="radio"/> Provincial hospital <input type="radio"/> All other sites	<input type="text"/> <input type="text"/>	Group <input type="radio"/> Individual <input type="radio"/> Family <input type="radio"/>	<input type="radio"/> <20 min. <input type="radio"/> 30-59 min. <input type="radio"/> Don't know <input type="radio"/> 20-29 min. <input type="radio"/> 60+ min.
<input type="radio"/> Provincial hospital <input type="radio"/> All other sites	<input type="text"/> <input type="text"/>	Group <input type="radio"/> Individual <input type="radio"/> Family <input type="radio"/>	<input type="radio"/> <20 min. <input type="radio"/> 30-59 min. <input type="radio"/> Don't know <input type="radio"/> 20-29 min. <input type="radio"/> 60+ min.
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Shade circles like this:
Not like this:

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CMHEI - Service/ Resource Use Form - F2

Non-psychiatrist Health Professional Visits Log

(Please print using BLOCK letters and numbers inside boxes)

SU - F2
FAM
pg 2/5

ID:

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Date (mm/dd/yy):

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Person Completing Form:

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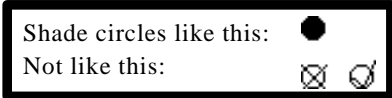
Indicate Period: Baseline Follow-up 3
 Follow-up 1 Follow-up 4
 Follow-up 2

In the PAST 30 DAYS did the consumer visit a physician (non-psychiatrist) in any setting or another health professional in an office-based practice?

- Yes **If yes, complete one line for each type of service:**
 No **If no or unknown, go to next page.**
 Unknown

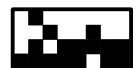
Type of visit*	Provider**	Location	Province (if not ON)	Average length of visit			Number of visits				
<input type="checkbox"/>	<input type="radio"/> Physician <input type="radio"/> Other	<input type="radio"/> Provincial hospital <input type="radio"/> All other sites	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			<input type="radio"/> <20 mins <input type="radio"/> 20-29 mins	<input type="radio"/> 30-59 mins <input type="radio"/> 60+ mins	<input type="radio"/> Don't know	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>		
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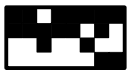
Type*: 1= mental health 5= foot care
 2= eye care 6= lab tests
 3= dental care 7= other physical health
 4= ear care 8= other



Provider:** "Other" refers to non-physician health professional, e.g., dentist, podiatrist, social worker.

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CMHEI - Service/ Resource Use Form - F2

Community Services and Support Programs Log

(Please print using BLOCK letters and numbers inside boxes)

SU - F2
FAM
pg 3/5

ID:

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Date (mm/dd/yy):

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Person Completing Form:

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Indicate Period: Baseline Follow-up 3
 Follow-up 1 Follow-up 4
 Follow-up 2

Has the consumer used community services and support programs during the **PAST 30 DAYS?**

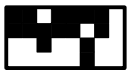
- Yes If yes, complete the following for each program:
 No If no or unknown, go to next page.
 Unknown

Name of Program/ Agency	City (enter first 6 letters)	Province (if not ON)	Program Type*	Total contacts in past 30 days	Contacts in past 30 days which were in a group	Contacts in past 30 days which were on the phone	Total # weeks attended in past 30 days	Average hours per week (for weeks attended)														
		<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td></tr></table>		<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td></tr></table>		<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				
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Program Type*:	0 = substance abuse 1 = Social/ recreational 2 = Vocational/ educational 3 = Crisis 4 = Housing	5 = Medical/ therapeutic 6 = Case management 7 = Self-help/ consumer initiative 8 = Legal advocacy 9 = Other
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CMHEI - Service/ Resource Use Form - F2 Emergency Room Visits Log

(Please print using BLOCK letters and numbers inside boxes)

SU - F2
FAM
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ID:

Date (mm/dd/yy): / /

Person Completing Form:

Indicate Period: Baseline Follow-up 3
 Follow-up 1 Follow-up 4
 Follow-up 2

Has the consumer used emergency room services during the PAST 90 DAYS ?

- Yes
- No
- Unknown

If yes, complete the following for each ER visit:

If no or unknown, go to next page.

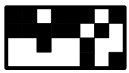
Name of Hospital for ER visit (enter first 15 letters)	City (enter first 6 letters)	Province (if not ON)	Purpose* (check all that apply)	Stayed overnight in holding bed?	Led to a hospital admission?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Psy <input type="radio"/> Med <input type="radio"/> SA <input type="radio"/> Oth	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Psy <input type="radio"/> Med <input type="radio"/> SA <input type="radio"/> Oth	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Psy <input type="radio"/> Med <input type="radio"/> SA <input type="radio"/> Oth	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Psy <input type="radio"/> Med <input type="radio"/> SA <input type="radio"/> Oth	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Psy <input type="radio"/> Med <input type="radio"/> SA <input type="radio"/> Oth	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Psy <input type="radio"/> Med <input type="radio"/> SA <input type="radio"/> Oth	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Psy <input type="radio"/> Med <input type="radio"/> SA <input type="radio"/> Oth	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Psy <input type="radio"/> Med <input type="radio"/> SA <input type="radio"/> Oth	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Psy <input type="radio"/> Med <input type="radio"/> SA <input type="radio"/> Oth	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

Purpose*: Psy = Psychiatric
SA = Substance Abuse
Med = Medical
Oth = Other

Shade circles like this: ●
Not like this: ⊗ ⊕

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CMHEI - Service/ Resource Use Form - F2

Prescribed Psychotropic Medication Log

(Please print using BLOCK letters and numbers inside boxes)

SU - F2
FAM
pg 5/5

ID:

Date (mm/dd/yy): / /

Person Completing Form:

Indicate Period: Baseline Follow-up 3
 Follow-up 1 Follow-up 4
 Follow-up 2

Have psychiatric/ substance abuse medications been dispensed to the consumer during the PAST 30 DAYS?

- Yes **If yes, complete the following for each medication:**
 No **If no or unknown, go to next page.**
 Unknown

Prescription Name (enter first 11 characters)	Type*	Prescribed Dose <i>Indicate mg per dose (if not available, indicate number of pills/ injections taken at one time)</i>	# doses in 24 hour period prescribed (if injection, PRN, see below)	During past month, # days for which medication or injection was dispensed
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OR <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> mg # pills/ injections	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OR <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> mg # pills/ injections	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OR <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> mg # pills/ injections	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OR <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> mg # pills/ injections	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OR <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> mg # pills/ injections	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OR <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> mg # pills/ injections	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OR <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> mg # pills/ injections	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OR <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> mg # pills/ injections	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OR <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> mg # pills/ injections	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

Type*: 1 = Sleeping pills or other sedatives (e.g. Halcion, Dalmane)
2 = Antidepressant or mood stabilizing medications (e.g. Prozac, Elavil, Lithium)
3 = Tranquillizers (e.g. Ativan, Valium)
4 = Analgesics or painkillers (e.g. Demerol, Darvon)
5 = Anti-psychotics (e.g. Haldol, Modecate)
6 = Substance abuse treatment (e.g. Methadone, Antabuse)
7 = Other

Indicate:
97 = PRN
98 = Injection
99 = Unknown

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