Sunnybrook
FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE

FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE
Intensive OCD Program Referral
Supplemental Client Form

CLIENT IDENTIFICATION

General Inquiries: (416) 480-4002
Referral Status: (416) 480-4426
Fax: (416) 480-5766
Email: thompsoncentreclinic@sunnybrook.ca
Website: www.sunnybrook.ca/thompson

This form is intended to be submitted as part of the Intensive OCD Live-In and Day Treatment Program referral, along with:

- **Severe OCD Services Referral Form**
- **Intensive OCD Program Referral: Supplemental Physician Form**
- **Psychiatric consult note or discharge summary from psychiatric admission**

All components must be submitted in order for the referral to be processed.
Refer to the **Severe OCD Services Referral Form** or the Thompson Centre website for full program information and eligibility criteria.

Date (yyyy/mm/dd): _____

DEMOGRAPHIC INFORMATION

Legal marital status:
- ○ Married
- ○ Living common law
- ◉ Never married (not living common law)
- ○ Divorced (not living common law)
- ○ Separated (not living common law)
- ○ Widowed (not living common law)

If married or with partner, for how long?

Do you have children? ○ Yes ○ No

If yes above, please list below:

Name	Age

What language(s) do you feel most comfortable speaking in with your provider?

Were you born in Canada? ○ Yes ○ No

If no above, when did you arrive in Canada?
- ○ Less than five years ago
- ○ Five to nine years ago
- ○ 10 years ago, or more

Do you identify as First Nations, Métis and/or Inuk/Inuit? Check all that apply. This question is about how you identify yourself (e.g., includes status or non-status).
- ☐ Yes, First Nations
- ☐ Yes, Inuk/Inuit
- ☐ Yes, Métis
- ☐ No
- ☐ Do not know

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CURRENT HEALTHCARE PROVIDERS

Current Family Doctor

Name:		Number of years involvement:
Street address:		
City/town:	Province: ON	Postal code:
Phone number:		

Current Psychiatrist

Name:		Number of years involvement:
Street address:		
City/town:	Province: ON	Postal code:
Phone number:		

Other Treatment Providers

E.g., psychologist, therapist, social worker, case manager, etc.

Name:		Number of years involvement:
Role:	Organization:	
Phone number:		
Do you consent for Sunnybrook to disclose your personal health information to this provider?	◯ Yes	◯ No

Name:		Number of years involvement:
Role:	Organization:	
Phone number:		
Do you consent for Sunnybrook to disclose your personal health information to this provider?	◯ Yes	◯ No

Name:		Number of years involvement:
Role:	Organization:	
Phone number:		
Do you consent for Sunnybrook to disclose your personal health information to this provider?	◯ Yes	◯ No

Name:		Number of years involvement:
Role:	Organization:	
Phone number:		
Do you consent for Sunnybrook to disclose your personal health information to this provider?	◯ Yes	◯ No

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OCD-RELATED INFORMATION
At what age did the obsessions or compulsions begin?
Describe your OCD in detail. Describe how it impacts your daily activities and relationship, such as self-care (showering, getting dressed, meal-preparation); productivity (work, school); leisure (social involvement; hobbies); relationships (family, friendships).
What triggers your OCD behaviours?

Motivation for Attending the Program

Describe why you want to come to this program (as opposed to why others may want you to come).
Describe any barriers that you feel might get in the way of your success in the program. Have you thought about what it will take to overcome those barriers?

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Add below anything that has not been covered in this form that you feel could help us understand your problem:

The following question is to be completed by a family member or someone currently living with you or close to you.

In the space below: comment on your observations of the patient's behaviours, the ways in which you may accommodate their OCD and how their OCD affects the household.
Relationship to client:

EDUCATION AND EMPLOYMENT STATUS

What is your current level of education?

- ○ No formal schooling
- ○ Grade school (grade 1-8)
- ○ Some high school, but did not graduate
- ○ High school or high school equivalency certificate
- ○ Completed Registered Apprenticeship or other trades certificate or diploma (or ongoing)
- ○ College, CEGEP or other non-university certificate or diploma (or ongoing)
- ○ Undergraduate degree or professional designation (Master's, PhD, MD)
- ○ Do not know

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Indicate below if you are currently: (check all that apply)

- ☐ Working — *If so,* ☐ Full-time ☐ Part-time ☐ Casual
- ☐ Attending school — *If so,* ☐ Full-time ☐ Part-time
- ☐ Volunteering
- ☐ None of the above

If you are not working or attending school, when was that last time that you did so?

If you are not working or attending school, was your discontinuation of work/school OCD-related?
○ Yes ○ No
If yes above, describe below:

Are you currently receiving any regular monthly income support? ○ Yes ○ No
If yes above, describe your source(s) of income below:

LEGAL ISSUES

Are you currently involved with the criminal justice system (e.g., probation, parole, hearing pending, forensic treatment, etc.)? ○ Yes ○ No
If yes above, describe below:

SOCIAL HABITS

Do you use tobacco products? ○ Yes ○ No
If yes above, how much/often?

How long have you been using tobacco products?

Do you drink alcohol? ○ Yes ○ No
If yes above, how many drinks per week?

Do you use recreational drugs? ○ Yes ○ No
If yes above, what type(s)?

How often?

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FAMILY MEDICAL HISTORY	☐ Not applicable
Describe any serious medical conditions that may run in your family (e.g., Huntington's disease, Alzheimer's, etc.)	

FAMILY PSYCHIATRIC HISTORY	☐ Not applicable

Use the table below to indicate whether you or your family members have a history of the following:

Condition	**You**	**Relative** (e.g., mother, father, sister)	**Description**
OCD	✓		
Hoarding Disorder	☐		
Other OCD-related disorders (compulsive hair-pulling disorder, compulsive skin-picking disorder, body dysmorphic disorder)	☐		
Major mood disorders (depression, bipolar affective disorder, manic-depressive illness)	☐		
Schizophrenia or other psychotic disorder	☐		
Eating disorder	☐		
Other anxiety disorder (panic disorder, phobia, PTSD, social anxiety disorder)	☐		
Substance use disorder (e.g., alcohol, cannabis, other substances)	☐		
ADHD	☐		
Suicide (history of attempts or completions)	☐		
Other diagnosed mental health disorders	☐		

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TRAUMA HISTORY

Do you have a history or trauma, such as physical or sexual abuse? ○ Yes ○ No ○ Prefer not to answer

If yes above, describe below: ☐ Prefer not to answer

Has anyone ever diagnosed you with Post-Traumatic Stress Disorder (PTSD)?
○ Yes ○ No

Have you ever engaged in self-injurious behaviour (e.g., cutting, burning) in the past?
○ Yes ○ No
If yes above, describe below:

Do you currently engage in self-injurious behavior (e.g., cutting, burning)?
○ Yes ○ No
If yes above, describe below:

ACCOMMODATIONS

Could you benefit from any support/accommodations related to a disability (e.g., mobility, sensory, cognitive, etc.)? ○ Yes ○ No
If yes above, describe below:

Do you have any dietary restrictions (including anaphylaxis)? ○ Yes ○ No
If yes above, describe below:

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QUALITY OF LIFE ENJOYMENT AND SATISFACTION QUESTIONNAIRE – SHORT FORM (Q-LES-Q-SF)

Taking everything into consideration, during the past week how satisfied have you been with your……

	Very poor	Poor	Fair	Good	Very Good
…..physical health?	○ 1	○ 2	○ 3	○ 4	○ 5
…..mood?	○ 1	○ 2	○ 3	○ 4	○ 5
…..work?	○ 1	○ 2	○ 3	○ 4	○ 5
…..household activities?	○ 1	○ 2	○ 3	○ 4	○ 5
…..social relationships?	○ 1	○ 2	○ 3	○ 4	○ 5
…..family relationships?	○ 1	○ 2	○ 3	○ 4	○ 5
…..leisure time activities?	○ 1	○ 2	○ 3	○ 4	○ 5
…..ability to function in daily life?	○ 1	○ 2	○ 3	○ 4	○ 5
…..sexual drive, interest and/or performance?*	○ 1	○ 2	○ 3	○ 4	○ 5
…..economic status?	○ 1	○ 2	○ 3	○ 4	○ 5
…..living/housing situation?*	○ 1	○ 2	○ 3	○ 4	○ 5
…..ability to get around physically without feeling dizzy or unsteady or falling?*	○ 1	○ 2	○ 3	○ 4	○ 5
…..your vision in terms of ability to do work or hobbies?*	○ 1	○ 2	○ 3	○ 4	○ 5
…..overall sense of well-being?	○ 1	○ 2	○ 3	○ 4	○ 5
…..medication? (If not taking any, check here ☑ and leave item blank.)	○ 1	○ 2	○ 3	○ 4	○ 5
…..How would you rate your overall life satisfaction and contentment during the past week?	○ 1	○ 2	○ 3	○ 4	○ 5

**If satisfaction is very poor, poor or fair on these items, please UNDERLINE the factor(s) associated with a lack of satisfaction.*

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