



Centre
for Addiction and
Mental Health
Centre de
toxicomanie et
de santé mentale

**MOOD AND ANXIETY DAY TREATMENT PROGRAM
INTAKE ASSESSMENT PILOT**

addressograph

Review client contact information.

Review DTP philosophy, groups, group expectations, and schedule.

What does client identify as needs/goals that DTP could address: _____

What led to your referral to the Day Treatment Program?: _____

History of present hospitalization/episode: _____

Supports already in place (CAMH, community; If inpatient, what are the follow up plans):

History of Substance abuse/treatment: _____

History of self-harm: _____

History of aggressive behaviour: _____

History of conflict with the law/current charges: : _____

Prior group experience: _____

Allergies:

Current Medications and doses:

MEDICATION	DOSE

Review program assessment and outcome measures: Yes No

Comments/Potential Considerations: _____

Name of DTP staff

Date (dd/mm/yyyy)

Signature and credentials

DTP TEAM REVIEW RECOMMENDATIONS:

Admission to DTP Recommended Yes No

If No, elaborate and list recommendations made: _____

Print Name

Date (dd/mm/yyyy)

Signature and Credentials