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Email Form

Behavioral Health and Recovery Services

CONFIDENTIAL

Assisted Outpatient Treatment (AOT)

REFERRAL FORM

PLEASE NOTE the AOT Program does not have the authority to mandate medication or involuntary long term hospitalization/conservatorship.

IF THIS IS A PSYCHIATRIC EMERGENCY PLEASE CALL 911

Qualified Referral Party

Agency: _____ Name: _____ Relation to individual: _____

Phone: _____ Email: _____ Fax: _____

AOT Individual Information

MR#: _____

Name: _____ DOB: _____ Phone number _____

Address: _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____ Gender: _____

Identifying marks/tattoos _____

RACE/ETHNICITY:

☐ White/non-Hispanic ☐ Hispanic ☐ Native American/Alaskan ☐ African American ☐ Asian ☐ Unknown ☐ Multi-race ☐ Other

CURRENT LIVING SITUATION:

☐ Homeless ☐ Homeless Shelter ☐ Hospital ☐ Housing/Apt ☐ Jail/Correctional Facility ☐ Psychiatric Facility

☐ Sober Living ☐ Family ☐ Whereabouts/Hangouts: _____

INSURANCE: *check all that apply*

☐ Medi-Cal ☐ Medicare ☐ Private ☐ None ☐ Unknown ☐ Other _____

BENEFITS: *check all that apply and indicate amounts*

☐ **SSI** ☐ Other Income _____

_____

_____

MENTAL HEALTH:

IS THE INDIVIDUAL CURRENTLY RECEIVING MENTAL HEALTH SERVICES?

☐ Yes ☐ No If yes, Agency: _____ Phone: _____

Type of services provided: _____

Mental Health Diagnosis: _____

List Mental Health Medication: _____

☐ Takes meds regularly ☐ Sometimes takes meds ☐ Never takes meds ☐ No meds prescribed ☐ Takes meds most of the time

☐ Rarely takes meds ☐ Refuses Meds ☐ Unknown ☐ Other _____

SUBSTANCE ABUSE:

List type of substance abused and frequency: _____

☐ Never used ☐ Currently using ☐ Past use ☐ Unknown ☐

Individual received substance abuse treatment: ☐ Yes ☐ No

Stanislaus County
Behavioral Health and Recovery Services

INDIVIDUAL REFERRAL FORM CONTINUED

NAME: _____

MR#: _____

	List dates of Admission & Discharge	Describe reason for admission
Number of Arrests in the past 36 months:		
Number of Psych Hospitalizations in the past 36 months:		
Number of acts of serious violence towards self/others:		

Please complete the information below in as much detail as possible.

Describe the individual's IMMEDIATE RISK & SAFETY CONCERNS and most concerning behavior that occurred including danger to self and others.

Describe how the individual is UNLIKELY TO MAINTAIN SAFELY IN THE COMMUNITY WITHOUT SUPERVISION AND IS AT RISK OF DECLINING (e.g. unable to care for self or provide food, clothing, or shelter).

Describe the individual's HISTORY OF NON-COMPLIANCE WITH TREATMENT (has been offered the opportunity to participate in treatment and fails to engage).

For Administrative Use Only Date reviewed _____ Attempted to contact referring party on: _____

☐ Individual met AOT criteria ☐ Individual did not meet AOT criteria Reason: _____

Referring party informed on Date: _____ Staff name: _____

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