CONFIDENTIAL

EL DORADO COUNTY HEALTH & HUMAN SERVICES AGENCY, BEHAVIORAL HEALTH DIVISION
ASSISTED OUTPATIENT TREATMENT (AOT) REFERRAL FORM

Please note that the AOT Program does not have the authority to mandate medication or involuntary long-term hospitalization/conservatorship.

Please send completed form to: Email: AOT@edcgov.us; Fax: (530) 303-1526, or Mail: EDC HHSA, Behavioral Health, ATTN: Utilization Review, 768 Pleasant Valley Road, Suite 201, Diamond Springs, CA 95619

IF THIS IS A PSYCHIATRIC EMERGENCY PLEASE DIAL 911

***INSUFFICIENT DETAILS MAY DELAY THE REFERRAL PROCESS**

DATE COMPLETED: _____

Attach recent photo here

INDIVIDUAL COMPLETING REFERRAL

AGENCY: _____ **NAME:** _____ **RELATION TO CANDIDATE:** _____

PHONE: _____ **EMAIL:** _____ **FAX:** _____

AOT CANDIDATE INFORMATION

SSN: _____

Client ID: _____

LAST NAME: _____ **FIRST NAME:** _____ **GENDER:** ☐ MALE ☐ FEMALE ☐ OTHER: _____

DOB: _____ **HEIGHT:** _____ **WEIGHT:** _____ **HAIR COLOR:** _____ **EYE COLOR:** _____

ADDRESS: _____ **CITY:** _____ **ZIP:** _____
If homeless, specify location (e.g. corner of 6th/Vermont) (Required)

PHONE NUMBER: _____ **PREFERRED LANGUAGE:** _____ ☐ **CANDIDATE SERVED IN THE U.S. MILITARY**

RACE/ETHNICITY: ☐ WHITE/NON-HISPANIC ☐ HISPANIC ☐ NATIVE AMERICAN/ALASKAN ☐ AFRICAN AMERICAN ☐ ASIAN ☐ UNKNOWN ☐ MULTIRACE ☐ OTHER: _____

CURRENT LIVING SITUATION:

☐ HOMELESS ☐ HOMELESS SHELTER ☐ HOSPITAL ☐ HOUSING/APT ☐ JAIL/CORRECTIONAL FACILITY ☐ SOBRIETY
☐ PSYCHIATRIC FACILITY ☐ WITH FAMILY/ADULT ☐ UNKNOWN SPECIFY AGENCY: _____

INSURANCE: CHECK ALL THAT APPLY

☐ MED-ICAL ☐ MEDICARE ☐ PRIVATE ☐ NONE ☐ OTHER _____ ☐ UNKNOWN

BENEFITS: CHECK ALL THAT APPLY AND INDICATE AMOUNTS ☐ NONE

☐ GR RECIPIENT $ ____ ☐ V.A. $ ____ ☐ SSI $ ____ ☐ SSDI $ _____ ☐ PENDING ☐ UNKNOWN ☐ OTHER $ _____

CONSERVATORSHIP ☐ YES ☐ NO IF YES, PLEASE LIST DATES, PHONE NUMBERS AND NAMES:

SUBSTANCE ABUSE ☐ NEVER USED ☐ CURRENTLY USING ☐ PAST USE ☐ UNKNOWN AGE FIRST USED _____

LIST TYPE (S) OF SUBSTANCE ABUSED & FREQUENCY: _____

INDIVIDUAL RECEIVED SUBSTANCE ABUSE TREATMENT: ☐ YES ☐ NO TREATMENT PROGRAM _____

PHYSICAL HEALTH ISSUES AND MEDICATION: _____

MENTAL HEALTH DIAGNOSIS: _____

LIST MENTAL HEALTH MEDICATIONS: _____

COMPLIANCE WITH MENTAL HEALTH MEDICATION

☐ TAKES MEDS REGULARLY ☐ SOMETIMES TAKES MEDS ☐ NEVER TAKES MEDS ☐ NO MEDICATIONS PRESCRIBED
☐ TAKES MEDS MOST OF THE TIME ☐ RARELY TAKES MEDS ☐ REFUSES MEDS ☐ UNKNOWN ☐ OTHER: _____

IS THE INDIVIDUAL CURRENTLY RECEIVING MENTAL HEALTH SERVICES?

☐ YES ☐ NO IF YES, AGENCY: _____ PHONE: _____

TYPE OF SERVICES PROVIDED: _____

CONFIDENTIAL

EL DORADO COUNTY HEALTH & HUMAN SERVICES AGENCY, BEHAVIORAL HEALTH DIVISION

ASSISTED OUTPATIENT TREATMENT (AOT) REFERRAL FORM

Please note that the AOT Program does not have the authority to mandate medication or involuntary long-term hospitalization/conservatorship.

NAME: _____

Client ID: _____

	LIST DATES OF ADMISSION & DISCHARGE		DESCRIBE REASON FOR ADMISSION
NO. OF ARRESTS IN THE PAST 36 MONTHS: _____			
NO. OF PSYCH HOSPITALIZATIONS IN THE PAST 36 MONTHS: _____			

	LIST DATES	NO. OF TIMES POLICE HAVE BEEN CALLED	DESCRIBE ACT OF VIOLENCE
NO. OF ACTS OF SERIOUS VIOLENCE TOWARDS SELF: _____			
NO. OF ACTS OF SERIOUS VIOLENCE TOWARDS OTHERS: ____			

Please complete the information below in as much detail as possible, if more space is needed, please attach an additional sheet.

Describe candidate's **IMMEDIATE RISK & SAFETY CONCERNS** and most concerning behavior that occurred including danger to self and others

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

Describe the candidate'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:** _____

☐ **CANDIDATE MET AOT CRITERIA** ☐ **CANDIDATE DID NOT MEET AOT CRITERIA** ☐ **REFERRING PARTY INFORMED** **DATE:** _____ **STAFF NAME:** _____

REASON: _____