

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: _____

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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 REASON: _____ CANDIDATE DID NOT MEET AOT CRITERIA REASON: _____ REFERRING PARTY INFORMED DATE: _____ STAFF NAME: _____