

SACRAMENTO COUNTY ASSISTED OUTPATIENT TREATMENT (AOT) REFERRAL FORM



Email to AOT Referral Box: dhs-mh-aot@saccounty.gov

IF THIS IS A PSYCHIATRIC EMERGENCY, PLEASE CALL 988

***INSUFFICIENT DETAILS MAY DELAY THE REFERRAL**

Attach
recent
photo here

REFERRING PARTY INFORMATION Per WIC 5346 (b)(2)

DATE COMPLETED: _____ AGENCY NAME: _____ NAME: _____
 PHONE: _____ EMAIL: _____ FAX: _____
 Relation to Candidate: Adult Residing with Candidate Adult Family Member of Candidate Director of Treating Agency
 Treating Mental Health Professional Candidates Assigned Peace Officer, Parole Officer, Probation Officer Judge/Court

INDIVIDUAL COMPLETING REFERRAL (if different than referring party): _____

AOT CANDIDATE INFORMATION Per WIC 5346 (a)

SSN# (if known): _____ XREF# (if known) _____ AVATAR# (if known) _____
 LAST NAME: _____ FIRST NAME: _____ GENDER: _____
 DOB: _____ APPROX. HEIGHT: _____ APPROX. WEIGHT: _____ HAIR COLOR: _____ EYE COLOR: _____
 ADDRESS: _____ CITY: _____ ZIP: _____
 PHONE NUMBER: _____ PREFERRED LANGUAGE: _____ CANDIDATE SERVED IN THE U.S. MILITARY YES NO

PHYSICAL HEALTH ISSUES AND MEDICATION: _____
 MENTAL HEALTH DIAGNOSIS: _____
 LIST MENTAL HEALTH MEDICATIONS: _____

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

LIVING SITUATION:
 HOMELESS HOMELESS SHELTER HOSPITAL HOUSING/APT JAIL/CORRECTIONAL FACILITY SOBER LIVING ENVIROMENT
 PSYCHIATRIC FACILITY WITH FAMILY/ADULT UNKNOWN Current Location: _____

INSURANCE: CHECK ALL THAT APPLY
 MED-ICAL MEDICARE PRIVATE NONE OTHER UNKNOWN

BENEFITS: CHECK ALL THAT APPLY AND INDICATE AMOUNTS
 GA RECIPIENT \$ V.A. \$ SSI \$ SSDI \$ PENDING UNKNOWN OTHER \$ NONE

HIGH RISK CONCERNS CHECK ALL THAT APPLY
 HISTORY/ACCESS TO WEAPONS HISTORY OF FIRE SETTING REGISTERED SEX OFFENDER

CONSERVATORSHIP YES NO IS THERE A PETITION TO END CONSERVATORSHIP? Yes No Unknown
 IF YES, PLEASE INCLUDE NAME AND PHONE NUMBER OF THE CONSERVATOR _____

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

LIST TYPE (S) OF SUBSTANCE USED & FREQUENCY: _____
 INDIVIDUAL RECEIVED SUBSTANCE USE TREATMENT: YES NO IF YES, TREATMENT PROGRAM: _____

COMPLIANCE WITH MENTAL HEALTH MEDICATION
 TAKES MEDS REGULARLY SOMETIMES TAKES MEDS NEVER TAKES MEDS NO MEDICATIONS PRESCRIBED
 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: _____

Last NAME:

FIRST NAME:

XREF#

Avatar#

NO. OF ARRESTS IN THE PAST 36 MONTHS	LIST DATES OF INCARCERATION		DESCRIBE REASON FOR INCARCERATION

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

NUMBER OF SERIOUS ACTS, THREATS of, OR ATTEMPTS OF VIOLENCE IN THE LAST 48 MONTHS TOWARDS <u>SELF</u>	LIST NUMBER & DATE OF OCCURANCE		DESCRIBE THREATS, ACTS OF VIOLENCE, AND ATTEMPTED VIOLENCE

NUMBER OF SERIOUS ACTS, THREATS of, OR ATTEMPTS OF VIOLENCE IN THE LAST 48 MONTHS TOWARDS <u>OTHERS</u>	LIST NUMBER & DATE OF OCCURANCE		DESCRIBE THREATS, ACTS OF VIOLENCE, AND ATTEMPTED VIOLENCE

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

Last Name:

First Name:

XREF#

AVATAR #

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

Describe how the candidate is **UNLIKELY TO SURVIVE SAFELY IN THE COMMUNITY WITHOUT SUPERVISION AND DETERIORATING (5346(a)(3)(a))**

Describe how the candidate **NEEDS ASSISTED OUTPATIENT TREATMENT TO PREVENT RELAPSE OR DETERIORATION THAT WOULD LIKELY RESULT IN GRAVE DISABILITY OR SELF HARM TO SELF OR OTHERS (5436(a)(3)(B))**

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: