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Divisions
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Primary Health
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County of Sacramento

INSTRUCTIONS FOR THE ASSISTED OUTPATIENT TREATMENT (AOT) REFFERAL FORM

PLEASE LEAVE ANY UNKNOWN INFORMATION BLANK— DO NOT GUESS

PURPOSE: The purpose of the AOT referral form is for the referring party (person that is recommending the candidate for AOT) to provide necessary information for the candidate in need of AOT services. This form will be used by county staff to determine if the candidate meets criteria outlined in statute for acceptance into the AOT program. Should the candidate not meet criteria, county staff will assess the candidate to determine level of service need and linkage to other services available, including but not limited to other full service partnership (FSP) programs. County staff will contact the referring party to obtain additional information if needed to determine criteria for AOT programming.

SECTION 1: REFERRING PARTY INFORMATION

(Please provide as much information as is known, if unknown, indicate that in the sections provided.)

Date Completed: Provide the date the form was filled out.

Agency Name: Provide the name of the referring party agency, if applicable.

Name: Provide the name of person making the AOT referral.

Phone: Provide the contact number of the person making the AOT referral.

Email: Provide the email of the person making the AOT referral.

Fax: Provide the fax number of the person making the AOT referral.

Individual completing form: Provide name of persons completing form, if different from referring party.

Relation to Candidate: Please check the box that is most appropriate for the referring party relationship to candidate. (If the referring party does not fall under one of these classifications, they are unable to submit AOT referral per WIC 5346(b). Please see additional resources on Behavioral Health Services website Behavioral Health Services Home (saccounty.gov).

SECTION 2: AOT CANDIDATE INFORMATION

Please provide as much information as is known, if unknown, indicate that in the sections provided.

XREF or AVATAR#: (Mental Health Professional) Please provide XREF or AVATAR #, If Known

LAST NAME: Provide the last name of the AOT candidate.

FIRST NAME: Provide the first name of the AOT candidate.

GENDER: Provide the gender that the AOT candidate identifies as, **if known**.

DOB: Provide the AOT candidate's date of birth, **if known**.

APPROX. HEIGHT: Provide the height of the AOT candidate (Most Recent).

APPROX. WEIGHT: Provide the weight of the AOT candidate (Most Recent).

HAIR COLOR: Provide the AOT candidate hair color (Most Recent).

EYE COLOR: Provide the AOT candidate natural eye color.

ADDRESS: Provide the physical address (house number, and street address) for the AOT candidate
or

Last known location for those who may be unhoused (Encampments, Intersecting streets, or other identifying information of their last known location.) (Most Recent).

CITY: Provide the city where the physical address is located/ or last known area.

ZIP: Provide the zip code for the physical address/or last known area.

PHONE NUMBER: Provide the primary phone number for the AOT candidate, last known.

PREFERRED LANGUAGE: Provide AOT candidate preferred language, **if known**.

CANDIDATE SERVED IN THE U.S. MILITARY: Please check box indicating if the candidate served in the U.S. Military, **if known**.

PHYSICAL HEALTH ISSUES AND MEDICATION: Provide all diagnosed health issues and prescribed medications for the health issues, **if known**.

MENTAL HEALTH DIAGNOSIS: Provide mental health diagnosis, **if known**.

LIST MENTAL HEALTH MEDICATIONS: Provide prescribed mental health medication.

RACE/ETHNICITY: Provide the race/ethnicity that AOT candidate mostly identifies as, **if known**.

LIVING SITUATION: Check the box for the AOT candidate's most recent living situation, **if known**.

INSURANCE: Check the boxes with the AOT candidate insurance type, check all that apply, **if known**.

BENEFITS: Check all boxes that apply to the candidates benefit type, include amounts, **if known**.

HIGH RISK CONCERNS: Check all boxes that apply to the AOT Candidate.
CONSERVATORSHIP: Check all boxes that apply to the AOT candidate, if Yes, Please provide conservator name and contact number**, if known.**

SUBSTANCE USE: Check box that applies to the AOT candidate frequency in drug use. List known types of drugs used by AOT candidate and frequency, Provide name of substance Use treatment program(s) the candidate may have utilized in the past, **if known**.

COMPLIANCE WITH MENTAL HEALTH: Check one box that applies to AOT candidate compliance with psychotropic (mental health) medication**, if known.**

MENTAL HEALTH SERVICES: Check one box that applies to AOT candidate on whether they are currently receiving mental health services or currently being offered mental health services. If yes, provide agency where services is being provided, contact number, and types of service being provided**, if known.**

SECTION 3: AOT CRITERIA INFORMATION

Please provide as much information as is known, if unknown, indicate that in the sections provided.

NUMBER OF ARREST IN THE PAST 36 MONTHS: Provide the amount of times that the AOT candidate has been arrested in the last 36 months due to their mental health. Provide dates of incarceration and reasons for incarceration. If needed, attach an additional sheet**, if known.**

NUMBER OF HOSPITLIZATION IN THE PAST 36 MONTHS: Provide the amount of times that the AOT candidate has been hospitalized in the last 36 months due to their mental health. Provide dates of admission and discharge and reasons for admission. If needed, attach an additional sheet**, if known.**

NUMBER OF SERIOUS ACTS, THREATS of, OR ATTEMPTS OF VIOLENCE IN THE LAST 48 MONTHS TOWARDS SELF: Provide the amount of times and dates that the AOT candidate has threatened to cause serious harm, attempted to cause serious harm, acted and caused serious harm to themselves in the last 48 months. Provide amount of times and dates police have been called and reason for call, including acts, threats, or attempt of violence**, if known.**

NUMBER OF SERIOUS ACTS, THREATS OF, OR ATTEMPTS OF VIOLENCE IN THE LAST 48 MONTHS TOWARDS OTHERS: Provide the amount times and dates that the AOT candidate has threatened to cause serious harms, Attempted to cause serious harm, acted and caused serious harm to others in the last 48 months. Provide amount of times police have been called and reason for call, including acts, threats, or attempt of violence**, if known.**

IMMEDIATE RISK AND SAFETY CONCERNS: List and describe the AOT candidate's most concerning behaviors that occurred. Please include dangers to self and to others. If needed, attach an additional sheet.

UNLIKELY TO SURVIVE SAFELY IN THE COMMUNITY WITHOUT SUPERVISION AND IS AT RISK OF DETERIORATION: Describe how the AOT candidate is unlikely to survive without supervision in the community and is deteriorating. If needed, attach an additional sheet.

RISK OF RELAPSE OF DETERIORATION THAT WOULD RESULT IN GRAVE DISABILITY OR SERIOUS HARM TO SELF OR OTHERS: Describe how the AOT candidate needs Assisted Outpatient Treatment to prevent a relapse or deterioration that would likely result in grave disability or serious harm to self or others. If needed, attach an additional sheet.

HISTORY OF NON-COMPLAINCE WITH TREATMENT: Provide if the AOT candidate has been offered the opportunity to participate in treatment and has failed to engage. Provide as much information as possible including dates, type of treatment (psychiatric hospital, outpatient mental health provider) and outcome. If needed, attach an additional sheet.