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:

SACRAMENTO COUNTY BEHAVIORAL HEALTH SERVICES
ASSISTED OUTPATIENT TREATMENT (AOT) REFERRAL FORM

Last NAME: **FIRST NAME:** **XREF#** **Avatar#**

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

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

	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>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>			

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: