CONFIDENTIAL

COUNTY OF SANTA CLARA, BEHAVIORAL HEALTH SERVICES DEPARTMENT

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 via secure email to AOT@hhs.sccgov.org

IF THIS IS A PSYCHIATRIC EMERGENCY, PLEASE CONTACT BHSD CALL CENTER 1-800-704-0900, OR DIAL 911

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

DATE COMPLETED: _____

INDIVIDUAL COMPLETING REFERRAL

AGENCY: _____ **NAME:** _____ **RELATION TO INDIVIDUAL:** _____

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

AOT CANDIDATE INFORMATION

SSN: _____

Client ID: _____

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

DOB: _____

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

☐ MEDI-CAL ☐ 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 USE ☐ NEVER USED ☐ CURRENTLY USING ☐ PAST USE ☐ UNKNOWN AGE OF FIRST USE _____

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

INDIVIDUAL RECEIVED SUBSTANCE USE 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 individual's **IMMEDIATE RISK & SAFETY CONCERNS** and most concerning behavior that occurred including danger to self and others

Describe how the individual 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 individual'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: _____