Jefferson County Community Services
Assisted Outpatient Treatment (AOT)
Referral Form

Indicate need for language/interpretation services; specify language spoken other than **English**: _____________

## Identifying Data:

**Name**: ______________________________________

**Alias/Maiden**: ________________________________

**Preferred Pronouns**: ☐ He/His ☐ She/Her ☐ They/Them

**SS Number**: _________________________________

**DOB**: _______________________________________

**Current Phone Number**: _______________________

**Street**: ______________________________________

**City**: ________________________________________

**Zip**: ________________________________________

**Insurance Type**: ______________________________

**Policy Number**: ______________________________

**Veteran**: ☐ Yes ☐ No

## Emergency Contact:

**Name**: ___________________________________

**Relationship**: _____________________________

**Street**: __________________________________

**City**: ____________________________________

**Phone**: ___________________________________

**Nearest Relative**: __________________________

**Advanced Directives**: ☐ Yes ☐ No

## Referring Agent:

Name: _____________________________________

Title: ____________________________________

Agency: ____________________________________

Relationship: ______________________________

Phone Number: ______________________________

Email: ____________________________________

Date of Referral: ____________________________

Signature: _________________________________

## Other current/past providers:

☐ Case Management (Agency: _________________ )
☐ Probation (Officer: _________________________ )
☐ Parole (Officer: ____________________________ )
☐ Residential Services (CR or Apartment Program)
☐ Substance Abuse Treatment (Agency: ________________________________ )
☐ Adult Protective
☐ Rep Payee
☐ MIT
☐ Supported Housing

## Psychiatric Information:

**Psychiatric Providers:**

Therapist: ______________________________ Clinic: ______________________________

Psychiatrist: ______________________________ Clinic: ______________________________

**Diagnosis:**

Axis I: ______________________________ Code: ______________________________

Axis I: ______________________________ Code: ______________________________

Axis II: ______________________________ Code: ______________________________

Axis III: ______________________________ Code: ______________________________

**Current Psychiatric Medications:**

Name: ______________________________ Dose: ______________________________

Name: ______________________________ Dose: ______________________________

Name: ______________________________ Dose: ______________________________

Name: ______________________________ Dose: ______________________________

Name: ______________________________ Dose: ______________________________

Name: ______________________________ Dose: ______________________________

**Medical Providers:**

Medical Doctor: ______________________________ Comments: ______________________________

Specialist: ______________________________ Comments: ______________________________

Other: ______________________________ Comments: ______________________________

## AOT Eligibility Criteria:

A person may be considered for an AOT if they meet ALL of the following criteria: (PLEASE VERIFY)

1. ☐ Yes ☐ No Is at least 18 years of age and suffers from a mental illness

2. ☐ Yes ☐ No Is unlikely to survive in the community without supervision
Describe: ______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

3. ☐ Yes ☐ No Has a history of NON-COMPLIANCE with treatment for mental illness which has led to either **2 hospitalizations for mental illness in 36 months**, or resulted in at least **1 act of violence** towards self or others, or threats of serious physical harm to self or others, **within 48 months**.
Please provide dates and locations of hospitalizations and/or incarcerations:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

4. ☐ Yes ☐ No Is unlikely to accept the treatment recommended in the treatment plan.
Describe client's refusal to accept treatment: ___________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

5. ☐ Yes ☐ No Is in need of AOT to avoid relapse or deterioration that would likely result in serious harm to self or others.
Describe: ___________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Alerts: (abuse, assaultive behavior, weapons, threats, document all history of violence to self or others, history of non-compliance with **necessary medical treatment** which places the individual at significant **medical risk**)

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

*Complete Referral Form in as much Detail as possible. Referrals that are incomplete or that do not provide sufficient detail will be returned for additional information. Add additional pages if necessary.*

**Fax or send completed form to:**
Jefferson County Community Services
Attn: Alicia Ruperd, AOT Coordinator
175 Arsenal St.
Watertown, New York 13601
Phone: (315) 785-3283
Fax: (315) 785-5182

Additional Information: