|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Referral Form |  |  **Name:** | Last, First |  | **Date:**  | mm/dd/yyyy |   |
|  |  | **Address:**  | Click here to enter text |  | **City:** | Click here to enter text |   |
|  |  | **Phone:**  | (xxx) xxx-xxxx |  | **Email Address:**  | xxxxxxxx@email.com |   |
|  |  |  |  |  |  |  |   |
|  |  | **Best time to contact you by phone?** (mark "X" next to answer) |   |
|  |  |  | Morning: 8a-12p |  [ ]  |  |  |   |
|  |  |  | Afternoon: 12p-5p |  [ ]  |  |  |   |
|  |  | **What is the name of the person you are referring to Assisted Outpatient Treatment?** |   |
|  |  |  | Click here to enter text |   |
|  |  | **What is your relationship to that individual?** |  |  |  |   |
|  |  |  | Click here to enter text |   |
|  |  | **Why are you referring this individual to the Assisted Outpatient Treatment Program?** |   |
|  |  |  | Click here to enter text |   |
|  |  | **Is this individual currently connected to mental health treatment?** (mark "X" next to answer) |   |
|  |  |  | Yes |[ ]   |  |   |
|  |  |  | No | [ ]   |  |  |   |
|  |  |  |  If yes, please provide name and contact information for that provider. |   |
|  |  |  | Click here to enter text |   |
|  |  |  |  |  |  |  |   |
|  |  | **Details Regarding the Individual:** |  |  |  |   |
|  |  |  | *What are the strengths of this individual?* |  |   |
|  |  |  | Click here to enter text |   |
|  |  |  |  |  |  |  |   |
|  |  |  | *What are the interests/hobbies of this individual?* |  |   |
|  |  |  | Click here to enter text |   |
|  |  |  |  |  |  |  |   |
|  |  |  | *What frightens and calms this individual?* |  |   |
|  |  |  | Click here to enter text |   |
|  |  |  |  |  |  |  |   |
|  |  | **History of Mental Health Treatment**: |  |  |  |   |
|  |  |  | *History of psychiatric treatment in the community (provide dates, contact information, and details)?* |   |
|  |  |  | Click here to enter text |   |
|  |  |  |  |  |  |  |   |
|  |  |  | *History of psychiatric hospitalizations (provide dates, facilities, and details)?* |   |
|  |  |  | Click here to enter text |   |
|  |  |  |  |  |  |  |   |
|  |  | **Concerns Regarding Behavior:** |  |  |  |   |
|  |  |  | *Threats, Attempts, Acts of Violence towards him/herself?* |  |   |
|  |  |  | Click here to enter text |   |
|  |  |  |  |  |  |  |   |
|  |  |  | *Threats, Attempts, Acts of Violence towards others?* |  |   |
|  |  |  | Click here to enter text |   |
|  |  |  |  |  |  |  |   |
|  |  |  | *Interaction with law enforcement (Calls to police department, arrests)?* |   |
|  |  |  | Click here to enter text |   |
|  |  |  |  |  |  |  |   |
|  |  | \* Please note that an AOT Care Team member will contact you to review this information within one (1) business day |   |
|  |  |  |  |  |  |  |   |
|  |  |  |  |  |  |  |   |