|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | | | | | | |  |
|  |  |  |  |  | |  | |  |
|  |  |  |  |  | |  | |  |