LEWIS COUNTY
NEW YORK

ASSISTED OUTPATIENT TREATMENT (AOT)
Referral Form

Date of Referral: _____

Prospective AOT person's name: _____

Address: _____

Phone Number: _____ Message Number: _____

Legal Status: _____

Referred by: _____Agency:_____
**** see table below**
Address: _____

Phone Number: _____ Fax Number:_____

Current Psychiatric Services: YES NO

Current Provider: _____Phone Number: _____

Does the person have a history of past service involvement that worked for him/her? YES NO

Explain: _____

Is the person in immediate danger to self or others? YES NO

**** Who can request an AOT**

An adult roommate of the person	A parent, spouse, adult child or adult sibling of the person;
The director of a hospital where the person is hospitalized;	The director of a public or charitable organization, agency or home that provides mental health services to the person in whose institution the person resides;
A qualified psychiatrist who is either treating the person or supervising the treatment of the person for mental illness;	A licensed psychologist or licensed social worker who is treating the person for mental illness
The director of community services, or social services official of the city or county where the person is present or is reasonably believed to be present	A parole officer or probation officer assigned to supervise the person.

LEWIS COUNTY
NEW YORK

INFORMATION RELEASE AUTHORIZATION
Consent to AOT assessment

NAME:_____ DOB:_____

Part I – A. Consent to Release Information

For the purpose of Assisted Outpatient Treatment/Assessment (AOT), I authorize Lewis County AOT Coordinator and referring party/agency to:

obtain from ☐ provide to ☐

_____
Referring party
_____

_____

the following information:

____ AOT assessment results
____Treatment Summary & Recommendations
____Psychiatric Evaluation
____Social/Family History
____Physical/Medical History
____Psychological Testing
____Educational Testing
____ AOT referral form
____ Academic Status
____ Past & Current Agency/School Involvement
____ Other (Specify) _____
____ Medication log
____ Legal history
____ Other (Specify) _____

This information will be used for the following purpose(s):

____ Complete AOT assessment
____ Evaluation and Continuing Treatment
____ Other (specify)_____
____ Make the AOT referral
____Coordinating Care

Check either A or B

A. ☐ I hereby authorize the periodic release of the above information to the person, organization facility, or program identified above as often as necessary to plan for/provide care and treatment. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time.

My consent to release information to the person, organization, facility or program identified above will expire when I am no longer receiving services from such person, organization, facility or program, or one year from this date, whichever occurs first.

B. ☐ I hereby authorize the one-time release of the above information to the person, organization, facility, or program identified above. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time.

My consent to release information will expire when acted upon, or 90 days from this date, whichever occurs first.

LEWIS COUNTY
NEW YORK

Part 1 B Consent to AOT assessment

My signature acknowledges the AOT assessment process has been explained to me and I agree to participate in the assessment process.

Signature of Client/Person Acting for Client	Relationship	Date
Signature of Witness	Title	Date

Part II-Cancelation/Refusal to Release Information

☐ I hereby cancel my permission to release information indicated in Part I, to the person, organization, facility, or program whose name and address is:

_____

_____

_____

☐ I hereby refuse to authorize the release of information indicated in Part I to the person, organization, facility, or program whose name and address is:

_____

_____

_____

Signature of Client/Person Acting for Client	Relationship	Date
Signature of Witness	Title	Date

LEWIS COUNTY
NEW YORK

AOT Criteria: The Following 9 Conditions Should Be Present

1. Is the person at least 18 years of age? YES NO Age:_____DOB:_____

2. Is the person currently residing in Lewis County? YES NO

3. Is the person diagnosed as mentally ill? YES NO

Most Recent Diagnosis: Date of Dx: _____ By Whom: _____

_____ __ _____

4. Have all less restrictive options been explored with the person? YES NO

List options explored: _____

_____

_____

5. Based on clinical determination, is the person unlikely to survive safely in the community without supervision? YES NO

Reasons: _____

_____

6. Does the person have a history of noncompliance with treatment resulting in either:

A. Two hospitalizations for mental illness in approximately the last three years? YES NO

Verification: _____

_____

_____

OR

B. One act of violence towards self or others in approximately the last four years? YES NO

Verification: _____

_____

_____

LEWIS COUNTY
NEW YORK

OR

C. Threats of or attempts of serious physical harm to self or others in approximately the last four years? YES NO

Verification: _____

_____

_____

7. Is the person unlikely to voluntarily comply with recommended outpatient treatment? YES NO

Reasons: _____

_____

_____

8. Is the person in need of AOT, based upon history and current behavior, to prevent relapse or deterioration that would likely result in serious harm to self or others? YES NO

Reasons: _____

_____

_____

9. Is the person likely to benefit from AOT? YES NO

Reasons: _____

_____

_____

***Has an Enhanced Treatment Agreement been discussed or initiated with the person? YES NO**

If yes, please explain: _____

_____

Please send or fax completed form to:
Lewis County Community Services
Lewis County AOT Coordinator
7660 North State ST.
Lowville, NY 13667

LEWIS COUNTY
NEW YORK

Fax 1-315-377-3085