

Lewis 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: _____) | ☐ Adult Protective |
| ☐ Probation (Officer: _____) | ☐ Rep Payee |
| ☐ Parole (Officer: _____) | ☐ MIT |
| ☐ Residential Services (CR or Apartment Program) | ☐ Supported Housing |
| ☐ Substance Abuse Treatment (Agency: _____) | |

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:

Lewis County Community Services
Attn: Shawna Berry, Mental Health Services Coordinator
5274 Outer Stowe Street
Lowville, New York 13367
Phone: (315) 376-5744
Fax: (315) 377-3085

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