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: _____)
☐ 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:

Lewis County Community Services
Attn: Patricia Mooney, Mental Health Services Coordinator
5274 Outer Stowe Street
Lowville, New York 13367
Phone: (315) 376-5832
Fax: (315) 377-3085

Additional Information: