Assisted Outpatient Treatment
Referral Form

Please send all referrals to First Nations Community Healthsource at: AOT@fnch.org
Contact Number: 505-262-6520

Referral Date:

Referral Source/Agency: **Referral Email:** **Referral Phone:**

Petitioner Name/Title: **Petitioner Email:** **Petitioner Phone:**
Role of Petitioner: The petitioner is expected to attend the initial AOT court hearing to provide supporting information as to why the referred would benefit from AOT and what services are needed.

Petitioner Relationship to Client: ☐ Adult family member ☐ Adult roommate ☐ Surrogate decision maker (guardian)
☐ Director of hospital where client is hospitalized ☐ Director of agency where client lives & receives services
☐ Qualified Professional who is providing/supervising treatment currently or in the past 4 years
Definition of a Qualified Professional: Physician, Licensed or Prescribing Psychologist, Certified Nurse Practitioner or Clinical Nurse Specialist with a specialty in mental health, or Physician Assistant with a specialty in mental health

Client Information

Client Name:

Date of Birth: **Age:** **Gender**: ☐ Male ☐ Female ☐ Other
Must be at least 18 years of age

Address (if homeless, area frequented):
Must reside in Bernalillo County – or, if homeless, frequent Bernalillo County

Client's Phone Number: **Can we leave a message?** ☐ Yes ☐ No

Client's Email:

Emergency Contact: **Phone:** **Email:**

SSI:	☐ Yes	☐ No	☐ Unknown		
SSDI:	☐ Yes	☐ No	☐ Unknown		
Medicaid:	☐ Yes	☐ No	☐ Unknown	Medicaid MCO:	Medicaid #:
Medicare:	☐ Yes	☐ No	☐ Unknown	Medicare MCO:	Medicare #:

Insurance is not an eligibility requirement

Have you ever served in the U.S. Military or Coast Guard: ☐ Yes ☐ No

Ethnicity/Race: (Check all that apply)
☐ Hispanic/Latino ☐ White ☐ Black ☐ Asian/Pacific Islander
☐ Amer. Indian/Alaskan Native- Do you have a Tribal ID# ☐ No ☐ Yes; please list
☐ Other:

Preferred Language: ☐ English ☐ Spanish ☐ Other:

Marital Status: ☐ Married/Partnered ☐ Never Married ☐ Divorced ☐ Widowed ☐ Separated

Client's Current Residential Status:
☐ Homeless ☐ Housing Unstable ☐ Living with Family ☐ Living Independently ☐ Inpatient
☐ Group Home ☐ Incarcerated

Is the Current Residential Status Stable: ☐ Yes ☐ No; Please Indicate Why:

AOT Admission Criteria (Indicate the reasons for referral)

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Demonstrated history of lack of compliance with treatment for a mental disorder that has:
Must meet at least one of the criteria below (check all that apply):

- ☐ Been a significant factor in necessitating hospitalization or incarceration at least twice in the last 4 years
- ☐ Resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last 4 years
- ☐ Resulted in incarceration, detention, or hospitalization for 6 months or more *and* the person is to be discharged within the next 30 days or was recently discharged within the past 60 days.

Please describe the incidents used as qualifying events above:
Include dates, facilities, precipitating events ****Please attach any records or documentation in support of these events****

Acute Concerns: *Please describe acute concern(s), if applicable:*

- ☐ Safety (Client)
- ☐ Safety (Others)
- ☐ Food
- ☐ Shelter
- ☐ Medical
- ☐ None

Please, explain why traditional case management or other voluntary community-based programs presented a challenge or were not appropriate for the referred.

Current DSM-5 Mental Health/Substance Use Diagnosis
Must have a primary diagnosis of a serious mental health disorder to be eligible for AOT.

Mental Health Diagnosis:
Substance Use Diagnosis:

- ☐ Yes; Please Indicate:
- ☐ No
- ☐ Unknown

Frequency of Substance Use:

- ☐ Never
- ☐ Active; Please List Substance:
- ☐ Past; Please List Substance:
- ☐ Unknown

Are you receiving Medication Assisted Treatment (MAT)?

- ☐ Yes; Please Indicate: Agency/Provider Name Phone:
- ☐ No
- ☐ Past; Please List Dates: Agency/Provider Name Phone:
- ☐ Unknown

Current Psychiatric Provider (if applicable):

- ☐ Yes; Please Indicate: Agency/Provider Name Phone:
- ☐ No

Current Psychiatric Medications (if applicable):
Significant Medical Needs:
Other Medications prescribed (if applicable):