SLC Assisted Outpatient Treatment/Enhanced Treatment Agreement Referral Form

Date of Referral: _____

Prospective AOT person's name: _____

Address: _____

Phone Number: _____ Message Number: _____

Legal Status: _____

Referred by: _____Agency:_____

Address: _____

Phone Number: _____ Fax Number: _____

Current Psychiatric Services: YES NO

Current Provider: _____

Address: _____

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

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 St. Lawrence County? YES NO**
3. **Is the person diagnosed as mentally ill? YES NO**

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

(CODE) **(DESCRIPTION)**

_____ _____

_____ _____

_____ _____

_____ _____

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: _____

_____

_____

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:

Lindsay Newvine
Mental Health Services Coordinator
99 West Main Street
Gouverneur, NY 13642

Fax: (315) 287-0285
Phone: (315) 229-3871