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: ____

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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: ____

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

Reasons: ____

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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: ____

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

Reasons: ____

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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: ____

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

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