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|  | **Fresno County Assisted Outpatient Treatment**  **(AOT) Referral Form**  *Please complete and email the form to* [*DBHAOT@fresnocountyca.gov*](mailto:DBHAOT@fresnocountyca.gov)  *Referrals are for adults only.*  *The AOT Program does not have the authority to mandate medication or*  *involuntary long-term hospitalization/conservatorship.*  *If you have any questions, please email* [*DBHAOT@fresnocountyca.gov*](mailto:DBHAOT@fresnocountyca.gov) | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Date: | |  | | | Referring Party Name/Agency: | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Referring Party Contact Phone Number(s): | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Referring Party Email Address: | | | | | | |  | | | | | | | | | | | |
| If Applicable, name of interpreter and language spoken by referring party: | | | | | | | | | | | | | | |  | | | |
| **Criteria 1: The referring party is 18 years or older and (must choose 1) (CA WIC § 5346):** | | | | | | | | | | | | | | | | | | |
|  | |  | Cohabitating with PersonParentSpouseSiblingChild of the PersonDirector of a Public or Private AgencyTreatment Facility **Charitable Organization** | | | | | | |  | | Licensed Residential FacilityDirector of a Hospital (where Person is currently hospitalized)Licensed Mental Health Treatment provider (supervising treatment of or providing treatment for Person)Peace/Probation/Parole Officer (assigned to Person)Superior Court Judge | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Person’s Name: | | | |  | | | | | | | | | Gender: | M  F  Other: | | |  | |
|  | | | | | | | | | | | | | | | | | | |
| Person’s Phone Number(s): | | | | | |  | | | | | | | | | | Birthdate: | | Click or tap to enter a date. |
|  | | | | | | | | | | | | | | | | | | |
| **Criteria 2: Is Person Served present or reasonably believed to be present within Fresno County (*CA WIC § 5346*)?**   **YES**  **NO** | | | | | | | | | | | | | | | | | | |
| Person’s Address/Location: | | | | | |  | | | | | | | | | | | | |
| **Criteria 3: Psychiatric Diagnoses (DSM 5): Check all that apply (*CA WIC § 5346 &******§ 5600.3):*** | | | | | | | | | | | | | | | | | | |
| PTSD Schizophrenia Bipolar Disorder **Substance Use Disorder(s):** | | | | | | | | | | | **Other severely disabling mental disorders (e.g., major affective disorders, disorders with symptoms of psychosis and/or that cause substantial functional impairments or symptoms, etc.):** | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **Criteria 4: Clinical determination (per treatment history and current behavior): Must choose at least 1 (*CA WIC § 5346*):** | | | | | | | | | | | | | | | | | | |
| **Person unlikely to survive safely in the community without supervision and their condition is substantially deteriorating.**  **If checked, please explain:** | | | | | | | | | | | | | | | | | | |
| **Person needs AOT in order to prevent relapse or deterioration that may result in grave disability or serious harm to the Person or others (*CA WIC § 5150*).**  **If checked, please explain:** | | | | | | | | | | | | | | | | | | |
| **Criteria 5: There is history of lack of adherence with Mental Health (MH) treatment at which:**  **Must choose at least 1 (*CA WIC § 5346*):**  ***\*Do not include any period during which person was hospitalized or incarcerated right before the filing of this form\**** | | | | | | | | | | | | | | | | | | |
| **Mental illness has resulted in Person needing hospitalization or services in a forensic or other MH unit of a state or local correctional facility at least 2x in the past 36 months (3 years.).**  **If checked, please explain:** | | | | | | | | | | | | | | | | | | |
| **Mental illness has resulted in 1 or more serious and violent behavior towards themselves or others or threats or attempts to cause serious physical harm to themselves or others in the past 48 months (4 years).**  **If checked, please explain:** | | | | | | | | | | | | | | | | | | |
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| **To be Completed by DBH Staff** | **Date Received:** |  |
| **Date Reviewed and Reviewed By:** |  |
| **Would participation in AOT be the least restrictive placement to ensure recovery and stability?** |  |
| **Date of Referral Approval or Denial\*:** |  |
| **\*If Referral is DENIED, explain why:** |  |