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|  | **Fresno County Assisted Outpatient Treatment****(AOT) Referral Form***Please complete and email the form to* *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* |
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| 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 Person ParentSpouse Sibling Child of the Person Director 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 |
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| Person’s Name: |       | Gender:  | [ ]  M [ ]  F [ ]  Other: |       |
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| Person’s Phone Number(s): |       | Birthdate: | Click or tap to enter a date. |
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| **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.):**       |
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| **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:** |       |