Referral Date: _____/_____/_____

Please send all referrals to wlgriffith@stpgov.org

AOT Phone Number: **(985) 809-5394**

Fax Number: **(985) 809-5381 Attn:AOT**

Referral Source/Agency: ______________________________ Referral Email: ______________________________

Referral Name: ______________________________ Referral Phone: ______________________________

Relationship: ______________________________ Alternate Phone: ______________________________

Reason for Referral:

Participants Name: ______________________________ ______________________________
Last / First

Date of Birth: _____/_____/_____ Age: __________ Gender: ☐ Male ☐ Female ☐ Other____________
Must be at least 18 years of age

Address (if homeless, area frequented): ______________________________

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

Emergency Contact: ______________________________/______________________________/______________________________
First/Last Name *Address* *Phone*

SSI: ☐ Yes ☐ No ☐ NA
SSDI: ☐ Yes ☐ No ☐ NA
Medicaid: ☐ Yes ☐ No ☐ NA

Client's Email: ______________________________

Insurance: ____________________ Medicaid #;____________________
Insurance is not an eligibility requirement

Ethnicity/Race: (Check all that apply)

☐ Hispanic/Latino ☐ Non-Hispanic ☐ White ☐ Black ☐ Amer. Indian/Alaskan Native

☐ Asian ☐ Pacific Islander ☐ Other: ______________________________

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

Living Arrangements: ☐ Currently Homeless ☐ Housing Unstable ☐ Living with Family ☐ Living Independently

☐ Inpatient ☐ Group Home ☐ Incarcerated ☐ Other

Assisted Outpatient Treatment
Referral Form

AOT Admission Criteria (Indicate the reasons for referral)

Demonstrated history of lack of compliance with treatment for a mental disorder that has:
(check all that apply):

- Been a significant factor in necessitating hospitalization or incarceration
- 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

Please describe the incidents :
Include dates, facilities, precipitating events

____
____
____

Acute Concerns

☐ Safety (Applicant) ☐ Safety (Staff) ☐ Food ☐ Shelter ☐ Medical ☐ None

Please describe acute concern(s), if applicable: ______________________________
____

Prior successful treatment/protocols if any:
____
____

Current DSM-5 Diagnosis.

Please list any known diagnosis, including substance use issues: ______________________
____
Must have a primary diagnosis of a serious mental disorder to be eligible for AOT.

Please describe any substance use: ☐ Current ☐ Past

____
Include substances, frequency of use and any known past treatment.

Current Psychiatric Provider (if applicable): ______________________ / ______________________
Name *Phone*

Current Psychiatric Medications (if applicable): ______________________________
____

Legal Power of Attorney	☐ Yes	☐ No	Name/Contact:______________________
Representative Payee	☐ Yes	☐ No	Name/Contact:______________________
Other Caretaker	☐ Yes	☐ No	Name/Contact:______________________
Receiving SSI/DI Benefits	☐ Yes	☐ No	Monthly Amount (if known):______________________