ASSISTED OUTPATIENT TREATMENT (AOT) REFERRAL FORM

***Please note that the AOT Program does not have the authority to forcibly medicate or seek involuntary long-term hospitalization.**

**** The Petitioner can be a family member; roommate; director of a hospital where person is hospitalized; director of an agency where the person lives and receives mental health services; qualified professional who is providing or supervising the treatment or has provided or supervised treatment in past 4 years; or surrogate decision maker, such as power of attorney or guardian**

If you believe you know someone who meets eligibility criteria for Assisted Outpatient Treatment, and will benefit from these services, then please complete this form. Please note: if you are not an eligible Petitioner and cannot identify an eligible Petitioner, then even if the person meets the AOT eligibility criteria, we cannot proceed with filing a petition for assisted outpatient treatment.

Please send all referrals to: HopeWorks at: aot@hopeworksnm.org. You will be contacted shortly about next steps in the AOT process.

INDIVIDUAL COMPLETING REFERRAL

DATE: ________________________ **AGENCY:** __________________________________ **NAME:** ___________________________________
PHONE: _______________________ **EMAIL:** ___________________________________ **FAX:** _____________________________________

PETITIONER INFORMATION

NAME: ___________________________________ **ADDRESS:** ____
PHONE: _______________________ **EMAIL:** __________________________________ **RELATION TO CANDIDATE:** _______________

AOT CANDIDATE INFORMATION

LAST NAME: _______________________ **FIRST NAME:** _______________________ **GENDER: MALE FEMALE** __________

DOB: _______________________ **MENTAL ILLNESS DIAGNOSIS:** ____

ADDRESS: ____ **CITY:** _____________________ **ZIP:** ___________
If homeless, specify location (e.g. corner of 1st/Mountain)

CELL: ____________________________ **OTHER CONTACT:** __________________ **PREFERRED LANGUAGE:** __________________

RACE/ETHNICITY: WHITE/NON-HISPANIC HISPANIC NATIVE AMERICAN/ALASKAN
AFRICAN-AMERICAN ASIAN UNKNOWN MULTIRACE OTHER___________

CURRENT LIVING SITUATION: STABILY HOUSED NOT HOUSED JAIL/PRISON HOSPITAL UNKNOWN

HIGH RISK CONCERNS: CHECK ALL THAT APPLY

History/Access to Weapons History of Fire Setting Registered Sex Offender

HISTORY OF INCARCERATION: YES NO **HISTORY OF HOSPITALIZATION:** YES NO

HISTORY OF VIOLENCE: YES NO

GUARDIANSHIP YES NO IF YES, PLEASE PROVIDE CONTACT INFO ____

REPRESENTATIVE PAYEE YES NO IF YES, PLEASE PROVIDE CONTACT INFO ____________________________________

SUBSTANCE USE NEVER USED CURRENTLY USING PAST USE UNKNOWN AGE FIRST USED________________

LIST TYPE(S) OF SUBSTANCE ABUSED & FREQUENCY:____

INDIVIDUAL RECEIVED SUBSTANCE ABUSE TREATMENT YES NO TREATMENT PROGRAM______________________

PHYSICAL HEALTH ISSUES AND MEDICATION:____

COMPLIANCE WITH MENTAL HEALTH TREATMENT:
YES SOMETIMES NEVER NO MEDICATIONS PRESCRIBED MOST OF THE TIME RARELY REFUSES UNKNOWN

IS THE INDIVIDUAL CURRENTLY RECEIVING MENTAL HEALTH SERVICES?
YES NO IF YES, AGENCY:____ PHONE:____________________________________

TYPE OF SERVICES PROVIDED:____