**Referral Date:**

**Referral Source/Agency**: **Referral email**: **Referral phone**:

**Petitioner Name/Title**: **Petitioner email**: **Petitioner phone**:

*Role of Petitioner: The petitioner is expected to attend the initial AOT court hearing to provide supporting information as to why the referred would benefit from AOT and what services are needed.*

**Petitioner Relationship to Client**: [ ]  Adult family member [ ]  Adult roommate [ ]  Surrogate decision maker (guardian)

[ ]  Director of hospital where client is hospitalized [ ]  Director of agency where client lives & receives services

[ ]  Qualified Professional who is providing/supervising treatment currently or in the past 4 years

*Definition of a Qualified Professional: Physician, Licensed or Prescribing Psychologist, Certified Nurse Practitioner or Clinical Nurse Specialist with a specialty in mental health, or Physician Assistance with a specialty in mental health.*

**Client Information**

**Client Name**:  **Date of Birth** (must be at least 18 years of age):

**Age**: **Gender**: [ ]  Male [ ]  Female [ ]  Other

**Address** (if homeless, area frequented):

*Must reside in Bernalillo County- or, if homeless, frequent Bernalillo County*

**Client’s Phone Number**: **Can we leave a message?** [ ]  Yes [ ]  No

**Client’s Email**:

**Emergency Contact**: **Phone**: **Email**:

**SSI**: [ ]  Yes [ ]  No [ ]  Unknown

**SSDI**: [ ]  Yes [ ]  No [ ]  Unknown

**Medicaid**: [ ]  Yes [ ]  No [ ]  Unknown Medicaid MCO: Medicaid#:

**Medicare**: [ ]  Yes [ ]  No [ ]  Unknown Medicaid MCO: Medicaid#:

*Insurance is not an eligibility requirement*

**Have you ever served in the U.S. Military or Coast Guard**: [ ]  Yes [ ]  No

**Ethnicity/Race**: (Check all that apply)

[ ]  Hispanic/Latino [ ]  White [ ]  Black [ ]  Asian/Pacific Islander

[ ]  American Indian/Alaskan Native- Do you have a Tribal ID#? [ ]  No [ ]  Yes; please list:

[ ]  Other:

**Preferred Language**: [ ]  English [ ]  Spanish [ ]  Other:

**Marital Status**: [ ]  Married/Partnered [ ]  Never Married [ ]  Divorced [ ]  Widowed [ ]  Separated

**Client’s Current Residential Status**: [ ]  Homeless [ ]  Housing Unstable [ ]  Living with Family

[ ]  Living Independently [ ]  Inpatient [ ]  Group Home [ ]  Incarcerated

**Is the Current Residential Status Stable**: [ ]  Yes [ ]  No; please indicate why:

**AOT Admission Criteria (Indicate the reasons for referral)**

**Demonstrated history of lack of compliance with treatment for a mental disorder that has:**

*Must meet at least one of the criteria below (check all that apply):*

[ ]  Been a significant factor in necessitating hospitalization or incarceration at least twice in the last 4 years.

[ ]  Resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical hard to self or others within the last 4 years.

[ ]  Resulted in incarceration, detention, or hospitalization for 6 months or more *and* the person is to be discharged within the next 30 days or was recently discharged within the past 60 days.

**Please describe the incidents used as qualifying events above:**

*Include dates, facilities, precipitating events***\*\*Please attach any records or documentation in support of these events\*\***

**Acute Concerns:** *Please describe acute concern(s), if applicable:*

[ ]  Safety (Client)

[ ]  Safety (Others)

[ ]  Food

[ ]  Shelter

[ ]  Medical

[ ]  None

**Please explain why traditional case management or other voluntary community-based programs presented a challenge or were not appropriate for the referred.**

**Current DSM-5 Mental Health/Substance Use Diagnosis**

*Must have a primary diagnosis of a serious mental health disorder to be eligible for AOT.*

**Mental Health Diagnosis**:

**Substance Use Diagnosis**:

[ ]  Yes, please indicate:

[ ]  No

[ ]  Unknown

**Frequency of Substance Use**:

[ ]  Never

[ ]  Active; please list substance:

[ ]  Past; please list substance:

[ ]  Unknown

**Are you receiving Medication Assisted Treatment (MAT)?**

[ ]  Yes, please indicate: Agency/Provider Name: Phone:

[ ]  No

[ ]  Past; please list dates: Agency/Provider Name: Phone:

[ ]  Unknown

**Current Psychiatric Provider (if applicable)**:

[ ]  Yes, please indicate: Agency/Provider Name: Phone:

[ ]  No

**Current Psychiatric Medications (if applicable)**:

**Significant Medical Needs**:

**Other Medications prescribed (if applicable)**: