Assisted Outpatient Treatment
Referral Form

Please send all referrals to HopeWorks at AOT@hopeworksnm.org

Referral Date: _____/_____/_____

HW AOT Phone Number: **(505) 764-8231 x309** Fax Number: **(505) 248-1351 Attn: AOT**

Referral Source/Agency:________________________________Referral Email/Phone:_______________________________

Petitioner Name/Title:____Petitioner Phone:__________________________

Petitioner Email: _______________________________Petitioner Address:____

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 Assistant with a specialty in mental health

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Client Name: _____________________________/___________________________
Last *First*

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

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

Emergency Contact:__________________________/______________________________________/____________________
First/Last Name *Address* *Phone*

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

Client's Current Status: ☐Inpatient ☐ Group Home ☐ Incarcerated ☐ Community

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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 1 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 harm 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

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

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

Explain why traditional case management or other community based programs are not appropriate for the referred.
____
____

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): ______________________________________
____

Treatment Guardian (***attach order***)	☐ Yes	☐ No	Name/Contact:______________________
Representative Payee	☐ Yes	☐ No	Name/Contact:______________________
Legal Guardian (***attach order***)	☐ Yes	☐ No	Name/Contact:______________________
Receiving SSI/DI Benefits	☐ Yes	☐ No	Monthly Amount (if known):______________