TERREBONNE ASSISTED OUTPATIENT TREATMENT (AOT) REFERRAL FORM

Email to AOT Referral Box: TerrebonneAOT@la.gov

IF THIS IS A PSYCHIATRIC EMERGENCY, PLEASE CALL 988
*INSUFFICIENT DETAILS MAY DELAY THE REFERRAL

REFERRING PARTY INFORMATION Per La. R.S. 28:67

DATE COMPLETED: _____ AGENCY NAME: _____ NAME: _____

PHONE: _____ EMAIL: _____ FAX: _____

Relation to Candidate: ☐ Adult Residing with Candidate ☐ Adult Family Member of Candidate ☐ Director of Treating Agency
☐ Treating Mental Health Professional ☐ Candidates Assigned Peace Officer, Parole Officer, Probation Officer ☐ Judge/Court

INDIVIDUAL COMPLETING REFERRAL (if different than referring party): _____

AOT CANDIDATE INFORMATION Per La. R.S. 28:66 (A)

SSN# (if known): _____

LAST NAME: _____ FIRST NAME: _____ GENDER: _____

DOB: _____ APPROX. HEIGHT: _____ APPROX. WEIGHT: _____ HAIR COLOR: _____ EYE COLOR: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE NUMBER: _____ PREFERRED LANGUAGE: _____ CANDIDATE SERVED IN THE U.S. MILITARY: YES ☐ NO ☐

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

LIVING SITUATION

☐ HOMELESS ☐ HOMELESS SHELTER ☐ HOSPITAL ☐ HOUSING/APT ☐ JAIL/CORRECTIONAL FACILITY ☐ SOBER LIVING ENVIROMENT
☐ PSYCHIATRIC FACILITY ☐ WITH FAMILY/ADULT ☐ UNKNOWN ☐ Current Location:

INSURANCE CHECK ALL THAT APPLY

☐ MEDICAID ☐ MEDICARE ☐ PRIVATE ☐ NONE ■ OTHER _____ ☐ UNKNOWN

BENEFITS CHECK ALL THAT APPLY AND INDICATE AMOUNTS

☐ SNAP $ ☐ V.A. $ ☐ SSI $ ☐ SSDI $ ☐ PENDING ☐ UNKNOWN ☐ OTHER $ _____ ☐ NONE

HIGH RISK CONCERNS CHECK ALL THAT APPLY

☐ HISTORY/ACCESS TO WEAPONS ☐ HISTORY OF FIRE SETTING ☐ REGISTERED SEX OFFENDER

CONSERVATORSHIP YES ☐ NO ☐ IS THERE A PETITION TO END CONSERVATORSHIP? ☐ Yes ☐ No ☐ Unknown

IF YES, PLEASE INCLUDE NAME AND PHONE NUMBER OF THE CONSERVATOR:

SUBSTANCE USE ☐ NEVER USED ☐ CURRENTLY USING ☐ PAST USE ☐ UNKNOWN AGE FIRST USED _____

LIST TYPE (S) OF SUBSTANCE USED & FREQUENCY: _____

INDIVIDUAL RECEIVED SUBSTANCE USE TREATMENT: ☐ YES ☐ NO IF YES, TREATMENT PROGRAM: _____

PHYSICAL HEALTH ISSUES AND MEDICATION:

MENTAL HEALTH DIAGNOSIS:

LIST MENTAL HEALTH MEDICATIONS:

COMPLIANCE WITH MENTAL HEALTH MEDICATION

☐ TAKES MEDS REGULARLY ☐ SOMETIMES TAKES MEDS ☐ NEVER TAKES MEDS ☐ NO MEDICATIONS PRESCRIBED
☐ MEDS MOST OF THE TIME ☐ RARELY TAKES MEDS ☐ REFUSES MEDS ☐ UNKNOWN OTHER: _____

IS THE INDIVIDUAL CURRENTLY RECEIVING MENTAL HEALTH SERVICES?

☐ YES ☐ NO IF YES, AGENCY: _____ PHONE: _____

TYPE OF SERVICES PROVIDED: _____

COMPLIANCE WITH MENTAL HEALTH SERVICES

- Regularly compliant with treatment
- Sometimes compliant
- Never compliant
- Mostly compliant with treatment
- Rarely compliant
- Refuses treatment
- Not enrolled in treatment

Has the individual gone to the hospital or emergency room multiple times for mental health concerns?

- Yes
- No
- Unknown

If yes, were these visits primarily:

- Voluntary
- Involuntary (e.g., by order or transport)
- Both
- Unknown

Please describe. Include any known details about how the individual arrived at the hospital (self-initiated, law enforcement, family, etc.)

Does the individual have a diagnosed or suspected intellectual or developmental disability (e.g., intellectual disability, autism spectrum disorder)?

- Yes
- No
- Suspected
- Unknown

If yes or suspected, please explain. Include diagnoses (if known), level of functioning, or any relevant support services the individual receives.

To the best of your knowledge, is the individual capable of understanding the AOT process and meaningfully participating in their treatment plan if enrolled?

- Yes
- No
- Uncertain

Has the individual had a psychiatric evaluation in the past 10 days?

- Yes
- No
- Uncertain

If yes, please provide the name of the facility, provider, or agency:

Can you attach a copy of the evaluation?

- Attached
- Will send separately
- Not available

Last Name: First Name:

	LIST DATES OF ADMISSION &DISCHARGE		DESCRIBE REASON FOR ADMISSION
NO. OF ARRESTS IN THE PAST 48 MONTHS RELATED TO MENTAL HEALTH:			
NO. OF PSYCH HOSPITALIZATIONS IN THE PAST 36 MONTHS:			

Any pending charges? ○ Yes ○ No If yes, explain:

	LIST DATES	NO. OF TIMES POLICE HAVE BEEN CALLED	DESCRIBE ACTS OF VIOLENCE
NO. OF ACTS OF SERIOUS VIOLENCE TOWARDS SELF:			
NO. OF ACTS OF SERIOUS VIOLENCE TOWARDS OTHERS Lb t ! {¢ oc a hb¢ l {Y			

Please complete the information below in as much detail as possible, if more space is needed, please attach an additional sheet.

Describe candidate's IMMEDIATE RISK & SAFETY CONCERNS and most concerning behavior that occurred including danger to self and others

Describe how the candidate is UNLIKELY TO SURVIVE SAFELY IN THE COMMUNITY WITHOUT SUPERVISION AND IS AT RISK OF DETERIORATION (e.g. unable to care for self or provide food, clothing, or shelter)

Describe the candidate's HISTORY OF NON-COMPLIANCE WITH TREATMENT (has been offered the opportunity to participate in treatment and fails to engage)

For Administrative Use Only **DATE REVIEWED:** _____ **ATTEMPTED TO CONTACT REFERRING PARTY ON:** _____

CANDIDATE MET AOT CRITERIA ☐ **CANDIDATE DID NOT MEET AOT CRITERIA** ☐ **REFERRING PARTY INFORMED** ☐ **DATE:** _____ **STAFF NAME:** _____

REASON: _____