



**CONFIDENTIAL**  
**LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH**  
**ASSISTED OUTPATIENT TREATMENT (AOT)**  
**CANDIDATE REFERRAL FORM**



*\*Please note that the AOT Program does not have the authority to mandate medication or involuntary long-term hospitalization/conservatorship.*

Please fax completed form to (213) 380-3680 or email [AOTLAOE@dmh.lacounty.gov](mailto:AOTLAOE@dmh.lacounty.gov) for more information call (213) 738-2440

**IF THIS IS A PSYCHIATRIC EMERGENCY PLEASE CALL ACCESS CENTER 1800-854-7771 OR DIAL 911**

**\*INSUFFICIENT DETAILS MAY DELAY THE REFERRAL PROCESS**

DATE COMPLETED: \_\_\_\_\_

**Attach  
recent  
photo here**

**INDIVIDUAL COMPLETING REFERRAL**

AGENCY: \_\_\_\_\_ NAME: \_\_\_\_\_ RELATION TO CANDIDATE: \_\_\_\_\_

PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_ FAX: \_\_\_\_\_

**AOT CANDIDATE INFORMATION**

SSN: \_\_\_\_\_

DMH IS#/IBHIS #: \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ GENDER: MALE FEMALE OTHER: \_\_\_\_\_

DOB: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ HAIR COLOR: \_\_\_\_\_ EYE COLOR: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

If homeless, specify location (e.g. corner of 6th/Vermont)

(Required)

PHONE NUMBER: \_\_\_\_\_ PREFERRED LANGUAGE: \_\_\_\_\_ CANDIDATE SERVED IN THE U.S. MILITARY \_\_\_\_\_

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

**CURRENT LIVING SITUATION:**

HOMELESS HOMELESS SHELTER HOSPITAL HOUSING/APT JAIL/CORRECTIONAL FACILITY SOBRIETY  
 PSYCHIATRIC FACILITY WITH FAMILY/ADULT UNKNOWN SPECIFY AGENCY: \_\_\_\_\_

**INSURANCE:** CHECK ALL THAT APPLY

MED-ICAL MEDICARE PRIVATE NONE OTHER \_\_\_\_\_ UNKNOWN

**BENEFITS:** CHECK ALL THAT APPLY AND INDICATE AMOUNTS

GR RECIPIENT \$ \_\_\_\_ V.A. \$ \_\_\_\_ SSI \$ \_\_\_\_ SSDI \$ \_\_\_\_ PENDING UNKNOWN OTHER \$ \_\_\_\_ NONE

**CONSERVATORSHIP** YES NO IF YES, PLEASE LIST DATES, PHONE NUMBERS AND NAMES:

**SUBSTANCE ABUSE** 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: \_\_\_\_\_

MENTAL HEALTH DIAGNOSIS: \_\_\_\_\_

LIST MENTAL HEALTH MEDICATIONS: \_\_\_\_\_

**COMPLIANCE WITH MENTAL HEALTH MEDICATION**

TAKES MEDS REGULARLY SOMETIMES TAKES MEDS NEVER TAKES MEDS NO MEDICATIONS PRESCRIBED  
 TAKES 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: \_\_\_\_\_



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NAME: \_\_\_\_\_

DMH IS#/IBHIS #: \_\_\_\_\_

	LIST DATES OF ADMISSION & DISCHARGE	DESCRIBE REASON FOR ADMISSION
NO. OF ARRESTS IN THE PAST 36 MONTHS: _____		
NO. OF PSYCH HOSPITALIZATIONS IN THE PAST 36 MONTHS: _____		

	LIST DATES	NO. OF TIMES POLICE HAVE BEEN CALLED	DESCRIBE ACT OF VIOLENCE
NO. OF ACTS OF SERIOUS VIOLENCE TOWARDS SELF: _____			
NO. OF ACTS OF SERIOUS VIOLENCE TOWARDS OTHERS: _____			

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: \_\_\_\_\_