PLEASE PRINT OR TYPE DIRECTLY ON THIS FORM

ASSISTED OUTPATIENT TREATMENT (AOT) REFERRAL

Date:	Referring Agency:	Date of Admission to Agency:

Client Name:	Date of Birth:	SHARES No.	UCI No.	SS No.

Is client a legal resident of Cuyahoga County? Yes ( ) No ( )

Does client have a guardian? Yes ( ) No ( )

Diagnosis:

Axis I:

Axis II:

Axis III:

Axis IV:

Is the client dually diagnosed (mentally ill/developmentally disabled, substance use disorder)? Yes or No

If yes, please indicate:

Client's psychiatric hospitalization history during the ***past 3 years***. (Please complete this section to the best of your ability.)

Hospital	Month/Year	Length of Stay	Reason for Admission

Persons who do not have repeated hospitalizations but are considered difficult to treat, generally non-responsive to treatment, and at high risk for hospitalization will also be considered. If the client meets this criteria, please describe:

Are there cultural issues which need to be considered when assigning this person to an AOT Team?

Primary language client speaks:

Describe the client's present living situation?

County of current living situation:

Does the client have any physical disabilities? Yes or No . If yes, describe:

Does the client have a history of substance use? Yes or No. If yes, describe the types of substances used e.g. alcohol, marijuana, crack/cocaine, prescription meds, etc. Is the client currently using substances? Is the client involved in any type of substance use treatment program?

Alcohol Drug History

Illegal Drug Use/Use in Past 12 Months: [ ] Yes [ ] No [ ] Unknown
Prescription Drug Use in Past 12 Months: [ ] Yes [ ] No [ ] Unknown
Non-Prescription Drug Use Past 12 Months: [ ] Yes [ ] No [ ] Unknown
Alcohol Use Past 12 Months [ ] Yes [ ] No [ ] Unknown

Toxicology Screen Completed: [ ] Not Indicated [ ] Yes [ ] No If yes, results:
Presenting with Detox Issue: [ ] Yes [ ] No If yes, symptoms:

Check all that apply: [ ] IV Drug User [ ] Inhalant [ ] Pregnant

Drug/Substance/Alcohol	Age of First Use	Date of Last Use	Frequency	Amount	Method

The ACT Model was designed for those clients in which traditional services has been unsuccessful in preventing or reducing repeated hospitalizations, homelessness, and remaining stable in the community. Please give a detailed description of interventions that have been used to engage client in traditional CSP and outcome of the interventions.

Rationale for referral to an AOT Team:

Have AOT services been discussed with the client and what is client's response?

Medication Information to include Medical, Psychotropic Medications, OTC

Medication	Rationale	Total Daily Dosage	Compliant			
			Yes	No	Partial	y

Name and Title of Person Completing this Form:	**Telephone Number:**
Name and Title of Authorizing Supervisor:	**Telephone Number:**

Print UbX fax cf a U]` completed referrals to:

Maggie Tolbert
Utilization Review Specialist
ADAMHS Board of Cuyahoga County
2012 West 25th Street 6th Floor
Cleveland, Ohio 44113-3199
FAX: 216-241-0805

<u>ADAMHSCC USE ONLY</u>:

Date Sent: _____/_____/_____

Agency:_________________________

Date of Acceptance:_____/_____/_____