NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES (NNAMHS)
ASSISTED OUTPATIENT TREATMENT (AOT) REFERRAL FORM

Section 1: Consumer Information

Date of Referral: Click or tap to enter a date.

Consumer Name: Click or tap here to enter text.

Avatar ID (if applicable): Click or tap here to enter text.

Address: Click or tap here to enter text.

Phone Number: Click or tap here to enter text.

SSN: Click or tap here to enter text.

DOB: Click or tap here to enter text.

Reason for Referral to NNAMHS AOT: Click or tap here to enter text.

Section 2: Referral Source Information

Referring Agency/Organization: Click or tap here to enter text.

Name of Referring Person: Click or tap here to enter text.

Phone Number: Click or tap here to enter text.

Address: Click or tap here to enter text.

Email: Click or tap here to enter text.

Section 3: Psychiatric/ Medical Information

Psychiatric Diagnosis/Diagnoses: Click or tap here to enter text.

Please describe history of psychiatric hospitalizations, emergency psychiatric services, or incarcerations within last 24 months (please list locations and dates): Click or tap here to enter text.

Please describe history of non-compliance with mental health treatment. List names of programs and dates of service: Click or tap here to enter text.

Current Psychiatrist: Click or tap here to enter text.

Current Psychiatric Medications: Click or tap here to enter text.

Medical Diagnoses: Click or tap here to enter text.

Primary Care Physician: Click or tap here to enter text.

Other known disabilities (physical, intellectual, etc.): Click or tap here to enter text.

History of harm to self, include history of suicide attempts: Click or tap here to enter text.

History of harm to others, include all verbal and physical acts of violence: Click or tap here to enter text.

Section 4: Substance Abuse

Please describe history of substance abuse treatment, including any inpatient/residential treatment programs, outpatient treatment programs, and emergency services (please list locations and dates of treatment): Click or tap here to enter text.

Substance Abuse History: Please describe client's substance use history as follows.

Substance:	Quantity:	Frequency:	Last Use:
_____________	___________	___________	____________
_____________	___________	___________	____________
_____________	___________	___________	____________
_____________	___________	___________	____________
_____________	___________	___________	____________
_____________	___________	___________	____________

Section 5: Legal Information

History of Legal Issues (list of all felony and misdemeanor charges, all incarcerations & dates, and current legal status):Click or tap here to enter text.

Section 6: Financial/ Benefits Information

Medical Insurance: Click or tap here to enter text.

Current Employment Status: Click or tap here to enter text.

Source of Income/Benefits (include amounts): Click or tap here to enter text.

Payee Information: Click or tap here to enter text.

Housing (please describe any history of homelessness and current housing situation): Click or tap here to enter text.

Section 7: Social Information

Family Involvement: Click or tap here to enter text.

Social Support: Click or tap here to enter text.

Employment/Volunteer History: Click or tap here to enter text.

THANK YOU!

- **Please email completed Referral Form to:** AOTReferralNNAMHS@health.nv.gov
- Whenever possible, please include supporting documents including (but not limited to):

1. Scanned copies of Medication Lists (Psychotropic, Medical, Over-the-Counter) or completed Medication Lists included at the end of this Referral Form;
2. Housing Contract and/or other detailed income information;
3. Completed and signed Release of Information forms to assist us in corroborating criteria for admission (e.g., Jail; private psychiatric facility; substance abuse program; detox);
4. Current Treatment Plans and/or Behavior Plans.