DENTON COUNTY MHMR CENTER
my health my resources

Denton County MHMR Assisted Outpatient Treatment (AOT) Referral Form

Please email the completed form to **AOT@dentonmhmr.org**

Referral Source Information		
Name (First, Last):		Date of Referral:
Phone:	Email:	
Relation to candidate:		
Agency/organization:		

AOT Candidate Information		
Name (First, Last):		
Phone:	Email:	
Address:	City:	Zip:
County:	Housing type:	
DOB:	Gender:	
Race/Ethnicity:	Veteran status:	
Insurance type:	Source of income (Check all that applies) ☐SSI ☐SSDI ☐EMPLOYED ☐OTHER INCOME ☐NONE	

AOT Candidate Support Information	
Does the candidate have a support person? No ☐ Yes ☐	Does the candidate have a Guardian? No ☐ Yes ☐
Support Person Name (First, Last):	Guardian Name (First, Last):
Support Person Phone:	Guardian Phone:
Support Person Email:	Guardian Email:

Psychiatric and Medical History

List any known psychiatric diagnoses:

List current medical and psychiatric medications:

List history of psychiatric hospitalizations/emergency services within the past 24 months:

Describe history of harm to self or others:

Describe current and past substance use including type, frequency, and participation in treatment:

Indicate any ongoing medical concerns:

List any physical illnesses, surgeries, head injuries or intellectual disabilities:

Criminal Justice System Involvement

List any arrests within the past 24 months including date, charge, and disposition:

List any incarcerations (jail or prison) within the past 24 months including date and length of stay:

Reason for Referral
Describe history of non-adherence to mental health treatment:
Describe immediate risk and safety concerns (ex. access to firearms or other weapons, fire setting, sexual offending behavior, substance use):
Describe how candidate is unlikely to survive safely in the community without supervision and is at risk of deterioration: