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

Referral Source
Date of Referral:
Agency:
Name:
Relationship to Consumer:
Phone: Email:

Please note: Prior to submitting referral, please review the NNAMHS AOT brochure for eligibility requirements. Insufficient and/or incomplete information may delay the referral process.

Consumer Demographic Information
Name:
Avatar ID (if applicable):
DOB:
SSN:
Gender:
Preferred Language:
Race/Ethnicity:
Address:
Phone:

Additional Required Information
Insurance:
Source of Income:
Payee:
Current Employment Status:
Guardianship (if applicable):
Qualifying Mental Health Diagnosis: Diagnosing Provider:
Mental Health Provider (if currently receiving services):
Current Psychiatric Medication:
Medication Compliance:
Primary Care Provider (if applicable):
Substance Abuse: Never Used ☐ Currently Using ☐ Past Use ☐ Unknown ☐
List Substances, Frequency, Date of Last Use, and SA Treatment History (if applicable):

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Number of Arrests in the Past 48 months (list dates, facility, and reason for arrest):
Number of Psychiatric Hospitalizations in the Past 48 months (list dates and facility):
Describe Consumer's History of Non-Compliance with Mental Health Treatment:
Describe Consumer's Immediate Risk and Safety (Including Concerns of Harm to Self and/or Others):
Describe How Consumer is Unlikely to Survive Safely in the Community Without Supervision and Is at Risk of Deterioration Without Assisted Outpatient Treatment:

THANK YOU!

Please email completed Referral Form to: AOTReferralNNAMHS@health.nv.gov
Or if you have further questions Please contact Heather Niel at 775-688-0462 or
Our Administrative assistant at 775-688-2143

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