ASSISTED OUTPATIENT TREATMENT PROGRAM REFERRAL

*****If referral is for an AOT violation, do not fill out this form. Instead contact the AOT Program. If your consumer is at imminent risk, call 911 then contact AOT Program*****

Date	**Referral Organization**
Referral Name	**Referral phone/email**
Consumer Name	**CHIP Case Number OR D.O.B. and SS#**

Consumer Information—SKIP if consumer has open CHIP record

Home Phone	**Cell Phone**	**Alt Phone**

Address

City	**State.**	**ZIP Code**

Insurance Information

Referral Information

1. **Is the consumer already on an AOT Order?** ☐ Yes ☐ No ☐ I don't know
2. **Reason for referral**: ☐Help obtaining an AOT ☐Questions about current AOT

   ☐Referral to AOT CM ☐Other:
3. **Clinical Concerns/Rational for referral:**
4. **Best day/time/method to contact consumer?**
5. **Known "hang-outs" of consumer?**

Return completed referral form to AOTProgram@genhs.org OR fax to 810-762-5234 Attn: AOT Program