Screening Checklist for Assisted Outpatient Treatment (AOT)

Patient Last Name_____ Patient First Name_____ M.I._____

Case Number_____Gender_____ DOB_____ Date of PC Admission_____

Name of person Completing the Form_____ Screening Date_____

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This screening checklist is recommended for all individuals within 30 days of admission. It should be reviewed prior to discharge to determine if the original recommendation should be updated to reflect new information or any clinically significant developments during the course of admission.

HISTORICAL CRITERIA

Note: The lookback period includes EITHER the immediate preceding years, OR the years prior to the current period of confinement which includes hospitalization periods and/or services received in a mental health unit of a correctional facility.

☐ **History of non-adherence with recommended treatment (with written documentation of same) that has resulted in:**

☐ **i.** **Inpatient History within 3 years (36 months) prior to the most recent hospital admission (must have two hospitalizations or receipt of services in a forensic or other mental health unit of a correctional facility).**
Dates of Hospitalizations:_____

☐ **ii.** **History of violence to Self or Others within the four years prior to the most recent date of admission (must have one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others).**

☐ **iii.** **Prior history on AOT within the past 6 months AND since the expiration has experienced a substantial increase in symptoms of mental illness, AND such symptoms substantially interferes with or limits one or more major life activities. (Criteria may only be used by prior DCS).**
Date of Expiration_____ County_____

Recommendation (Must Choose one of the following)

☐ **Meets Criteria for AOT-Petition will be filed with the court**	
☐ **On a current AOT order---Will coordinate renewal with the county**	
☐ **Meets Historical Criteria for AOT, BUT petition will not be filled due to the following rationale:** **If not filed, what enhanced services will be considered at discharge (Eg. MIT, HH+, ACT etc) ?:**	☐ **Does NOT meet Historical criteria for Assisted Outpatient Treatment (AOT)**

Staff Signature_____ Date_____

Title_____