AOT REMOVAL REQUEST FORM

Date: **Click or tap to enter a date.**

Director of Community Services   Nassau County Sheriff's Department
Nassau County Department of Mental Health,   Family Court
 CD & DDS   1200 Old Country Road
60 Charles Lindbergh Blvd., Suite 200   Westbury, NY 11590
Uniondale, New York 11553-3687

Client Name: **Click or tap here to enter text.**

Address:**Click or tap here to enter text.**

Current Physical Location: **Click or tap here to enter text.**

Ethnicity:	**Click or tap here to enter text.**	Height:	**Click or tap here to enter text.**
Sex:	**Click or tap here to enter text.**	Weight:	**Click or tap here to enter text.**
Age:	**Click or tap here to enter text.**	Color of Hair:	**Click or tap here to enter text.**
DOB:	**Click or tap here to enter text.**		

Dear Director/Sheriff:

Please be advised that in my clinical judgment, **Click or tap here to enter text.** at this time may be in need of involuntary admission to a hospital, pursuant to Mental Hygiene Law Section 9.27, or is a person for whom immediate observation, care and treatment may be necessary pursuant to Mental Hygiene Section 9.39 or 9.40. The Director of Community Services is requested to direct the removal of **Click or tap here to enter text.** to an appropriate hospital for examination to determine if he/she has a mental illness for which hospitalization is necessary pursuant to Mental Hygiene Law Section 9.27, 9.39 or 9.40.

Describe the noncompliance with court-ordered treatment plan: (*please be specific*)

Click or tap here to enter text.

What efforts have been made by the treatment team and/or case management to solicit compliance? (*please be specific, include dates where applicable*)

Click or tap here to enter text.

Current behaviors and/or psychiatric symptoms:

Click or tap here to enter text.

Risk factors:

Click or tap here to enter text.

Current Prescribed Medications:

Name of Agency Requesting Removal: **Click or tap here to enter text.**

Contact Name and Phone Number: **Click or tap here to enter text.**

Psychiatrist's Signature: _____ Printed Name: **Click or tap here to enter text.**

CC: NUMC E/R