COUNTY OF NASSAU
DEPARTMENT OF HUMAN SERVICES

OFFICE OF MENTAL HEALTH, CHEMICAL DEPENDENCY AND DEVELOPMENTAL DISABILITIES SERVICES

AOT RENEWAL RECOMMENDATION FORM

Client Name:		**Order Expires:**	Click or tap to enter a date.	**Form Due:**	Click or tap to enter a date.
Care Coordination:		**Treatment Provider:**		**Housing:**	

Client's Current Diagnosis:

Client's Current Prescribed *Psychiatric Medication* Regimen					
Medication Name Dosage/ Route/ Frequency (Therapeutic Range)	**Blood Monitoring**		**Contingency Medication Dosage/ Route/ Frequency (Therapeutic Range)**	**Blood Monitoring**	
	☐ Y	☐ N		☐ Y	☐ N
	☐ Y	☐ N		☐ Y	☐ N
	☐ Y	☐ N		☐ Y	☐ N
	☐ Y	☐ N		☐ Y	☐ N
	☐ Y	☐ N		☐ Y	☐ N
	☐ Y	☐ N		☐ Y	☐ N
	☐ Y	☐ N		☐ Y	☐ N

Describe Client's Compliance with Medication:

Would Client continue with their medication without an AOT Order? ☐ Y ☐ N

Describe Client's Compliance with Treatment:

Describe Client's insight into mental illness/need for treatment and attitude/commitment to treatment in the future:

Client Activity During AOT Order	**Current Order:**	Click or tap to enter a date.	Click or tap to enter a date.

List All Psychiatric Hospitalizations During Current Order: ***(Include hospital name, dates of admittance/discharge)***

List All 9.60 Removal Order Dates During Current Order:

List all Significant Event Report Dates During Current Order:

If Client has Substance Abuse Treatment, list all Toxicology Dates with Results/Refusals During Current Order:

Recommendations:								
AOT Renewal	☐ Y	☐ N	Substance Abuse Treatment	☐ Y	☐ N	Financial Management	☐ Y	☐ N
If adding a ***NEW*** category of service to the order, please list justification based on your clinical observations and submit supporting documentation, e.g., past due rental statements, toxicology results, etc.								

Based upon clinical observations, please provide evidence of respondent's treatment history and present circumstances that may impact their ability to remain in the community without supervision.

State clinical basis to Renew AOT Order:

The above recommendation has been discussed with the Housing Provider (SOCR, CR, Apt. Treatment) and Case Management Agency. All are in agreement:	☐ Y	☐ N
If No, please explain below:		

Treating Provider Signature:	Date:
Treating Provider Name:	
Treating Provider Credentials:	