DEPARTMENT OF HEALTH & SOCIAL SERVICES
BEHAVIORAL HEALTH DIVISION

ASSISTED OUTPATIENT TREATMENT
LAURA'S LAW REFERRAL

Email this to: AOTMH@solanocounty.com
BEHAVIORAL HEALTH DIVISION
Access Line: (800) 547-0495
Fax: (707) 425-4038

Referring Party: _____ Date: _____

Your Address: _____ Your Phone: _____

Your Email: _____ **Best time to contact you by phone?**

☐ Morning: 8a-12p ☐ Afternoon: 12p-5p

Name of Person Being Referred | **Their Address (Street Address, City)**

Their Birthdate: _____ **Their Phone:** _____

What is your qualifying relationship to that individual?

☐ Adult Family Member - Describe _____

☐ Adult residing with individual - Describe _____

☐ Director of treating agency/hospital - Describe _____

☐ Treating mental health professional - Describe _____

☐ Peace, parole, probation officer - Describe _____

Describe your psychiatric concerns that demonstrate deterioration due to lack of treatment:

Is this individual currently or previously connected to mental health treatment? ☐ Yes ☐ No

If yes and known, please provide name and contact information for that provider:

To qualify, the client has refused voluntary services that resulted in either :

☐ A. One attempt to harm self or others, involving law enforcement in the last 48 months

☐ B. Two psychiatric hospitalizations in the last 36 months

A. Threats, Attempts, Acts of Violence towards him/herself or others within the last 48 months

Interaction with law enforcement (Calls to police department, arrests)

B. Psychiatric hospitalizations within the last 36 month (provide dates, facilities, and details - if known)

Psychiatric treatment in the community (provide dates, contact information, and details - if known)