Siskiyou County Assisted Outpatient Treatment
Referral Form

Referral Source Name _____ **Date:** _____

Relationship to Defendant: _____

Defendant Name and DOB: _____ **Defendant County of Residence:** _____

Psychiatric Diagnosis _____

Brief history of Respondent's contact with law enforcement within the last 36 months:

Brief history of Respondent's psychiatric hospitalizations within the last four years:

Brief history of Respondent's mental health treatment within the last 36 months:

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Brief description of how the Respondent is a risk to themselves, others, or is gravely disabled (include information on how the defendant is able to currently care for themselves):

Brief description of how the defendant's condition has recently deteriorated:

Sincerely, _____ **Printed Name:** _____

Telephone number: _____

Address: _____

_____

Please submit the completed Family Contribution Form to Siskiyou County Behavioral Health

Mail or Drop Off:

2060 Campus Drive
Yreka, CA 96097

Fax:

(530) 841-4702

Attention: Access/AOT