STATE OF ILLINOIS

PSYCHIATRIC REPORT FOR AGREED OUTPATIENT ORDERS

Facility:_____ Date of Application:_____

Name of Admittee:_____ DOB:_____

Address of Admittee:_____

Phone # of Admittee:_____ E-Mail of Admittee:_____

(This report is written and submitted in preparation for the admittee's participation in the State of Illinois' Assisted Outpatient Program):

1. Patient's diagnosis and recent symptoms of a serious mental illness:_____
   _____
   _____
   _____
   _____
   _____
2. Patient's current treatment and progress (briefly describe):_____
   _____
   _____
   _____
   _____
3. Patient's suitability for discharge and appropriateness of outpatient services:
   a. Why the outpatient program would be the least restrictive setting:_____
      _____
      _____
      _____
      _____
   b. Why outpatient treatment for admittee is necessary and appropriate at this time:
      _____
      _____
      _____
      _____
   c. Is it your opinion that this order is in the best interests of the admittee and the community_____
4. Outpatient service provider(s) and contact information (please provide all names, addresses, phone numbers, email addresses and date, time, location of admittee's next appointment):_____
   _____

_____
_____

5. Potential custodian information (Name, address, telephone number and email address):_____
   _____
   _____
   _____
6. Patient's preliminary treatment for the agreed outpatient treatment (**required information** includes the name of the medication(s), the dosage ranges, the method of administration, and the frequency of administration under the AOT setting):
   _____
   _____
   _____
   _____
   _____
   _____
7. Patient's treatment goal (briefly describe):_____
   _____
   _____
   _____
   _____
8. The length of AOT time period sought (maximum is 180 days):_____
   _____

Treating Psychiatrist Signature:_____ Date: _____