Siskiyou County Assisted Outpatient Treatment
Family Contribution Form

AB 1976 requires that all individuals making decisions about involuntary assisted outpatient treatment consider information supplied by family members. This form provides a means for family members to communicate about their relative's mental health history to psychiatric and court authorities, who must read the information and keep a copy in a consumer's health chart or court record.

Date: _____

Dear Judge, Public Defender, County Counsel, and Clinical Director,

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

Relationship to Respondent: _____ **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:

Family request to the Court:

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