MANAGEMENT REQUESTED REFERRAL FOR EAP SERVICES

This form is to provide coordination of EAP services in response to a management request for EAP consultation. Please complete this form and fax to P.A.C.T. at 931-9413. Thank you for your assistance.

Supervisors Information:
Name: ____ Title: ________________________
Department: ____________________________________ Phone Number: ____________________
Fax Number: ________________________________ Email Address: ________________________
Mailing Address: ____
Employee Information:
Name: ____ SS#: ______________________________
Department: ____________________________________ Position: __________________________
Length of Employment: ______________________

Purpose for Management Requested Referral:
- ❑ Mandatory referral as component of Performance Improvement Plan;
- ❑ Evaluation of Fitness for Duty;
- ❑ ____

Follow-up information requested:
- ❑ Contact(s) with the EAP;
- ❑ Participation or non-participation in recommended plan of action;
- ❑ Continuation or discontinuation in recommended plan of action; and/or
- ❑ Status of Fitness for Duty
- ❑ ____

Additional Information: Please provide your comments below. Include Performance Review if possible/applicable.
Observed Problems or Areas of Concern:

Duration of Problems:

Precipitating Event for Referral (if applicable):