

Employee Assistance Program Workplace Referral Form

This form is not placed in the employee personnel file. Copies are prepared for the employee and the EAP consultant

Name of Employee _____ SS number _____

Job Title _____ Department _____ Phone # _____

Length of time with: a) company _____ b) current job _____ c) current supervisor _____

Primary referral source _____ Title _____ Phone # _____

Send QA survey? Yes ___ No ___ Address _____

Secondary referral source _____ Title _____ Phone # _____

REASON FOR REFERRAL

Please indicate current workplace problem area(s).

ABSENTEEISM

- | | |
|---|--|
| <input type="checkbox"/> Excessive absenteeism (how many days _____ in past
how many months _____)
Pattern (if any) <input type="checkbox"/> Beginning or end of work week
<input type="checkbox"/> Before/after holidays <input type="checkbox"/> Before/after paydays
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Frequent unscheduled leave requests
<input type="checkbox"/> Frequent sick leave or illness on the job
<input type="checkbox"/> Extended lunch periods or breaks
<input type="checkbox"/> Excessive lateness (describe) _____
<input type="checkbox"/> Early or unauthorized departures from workplace
<input type="checkbox"/> Other (describe) _____ |
| <input type="checkbox"/> Unusual excuses for absences | |

JOB PERFORMANCE, ATTITUDE, RELATIONSHIP, OR SAFETY

- | | |
|---|--|
| <input type="checkbox"/> Lower quality of work
<input type="checkbox"/> Decreased productivity (or alternating
periods of increased and decreased performance)
<input type="checkbox"/> Increased errors
<input type="checkbox"/> Impaired judgment, memory or ability to
concentrate
<input type="checkbox"/> Failure to follow procedures | <input type="checkbox"/> Failure to meet schedules
<input type="checkbox"/> Safety violations or accidents
<input type="checkbox"/> Frequent or intense arguments
<input type="checkbox"/> Verbal abusiveness
<input type="checkbox"/> Threatening or intimidating behavior
<input type="checkbox"/> Other (specify) _____
_____ |
|---|--|

POSITIVE DRUG SCREEN

Date of test _____ Type drug(s) _____ Level(s) _____

COMMENTS RELATING TO CURRENT WORKPLACE ISSUES

DESIRED IMPROVEMENT (What the employee must do to achieve satisfactory performance including time frame for improvements.) _____

CONSEQUENCES IF IMPROVEMENT IS NOT ACHIEVED

PREVIOUS STEPS OR DISCIPLINARY ACTION TO ADDRESS RELATED OR OTHER ISSUES

HAS THERE BEEN A PREVIOUS JOB PERFORMANCE REFERRAL TO THE EAP? yes Date _____ no

EAP APPOINTMENT SCHEDULE

Date _____ Time _____ EAP Consultant _____ Phone# _____

Location _____ Parking arrangements _____