

SUPERVISORY REFERRAL TO EAP BEST CARE EMPLOYEE ASSISTANCE PROGRAM

CENTER POINTE PROFESSIONAL PLAZA
9239 WEST CENTER ROAD
OMAHA, NEBRASKA 68124

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1-800-666-8606
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EAP strives to provide successful outcomes for supervisory referrals. It is helpful to have as much relevant information as possible for each supervisory case. Please clarify for the EAP Counselor any information which has not been shared with the employee or you do not wish to be shared with the employee. Please complete this form and promptly submit it to EAP when you make a supervisory referral.

(Supervisor or Company Representative's name)	(Employee's Name)
(Company)	(S.S. #)
(Address)	(Work phone #)
(Work phone #)	

Reason for Referral is due to: (check all that apply and please complete checklists on the other side)

1. Ongoing Performance Deficiencies:

2. Gradual Performance Deterioration: (please explain)

3. A Critical Incident: (please explain)

Employee's Current Level of Work Functioning (please circle one)
1. Outstanding 2. Above Average 3. Average 4. Below Average 5. Unsatisfactory

Supervisory Steps Already Taken (check all that apply)

(Please send/fax supportive documentation)

- 1. Discussion with employee regarding work performance problems.
How many discussions? _____ Dates _____
Does the employee clearly understand improvements expected from the referral to EAP?
Yes _____ No _____
- 2. Verbal warning.
- 3. Verbal and written warning.
- 4. Second written warning.
- 5. Suspension. Length? _____
- 6. Return-to-work agreement. Copy enclosed? Yes _____ No _____

Work Performance Problems Check List

Note: For each performance problem listed below, please check the appropriate box to the right, signifying the severity of the problem. Never = does not happen. Rarely = happens once in a while; not an issue. Occasionally = happens once in a while; is an issue. Frequently = happens with some regularity. Routinely = consistently happens.

	Never	Rarely	Occasionally	Frequently	Routinely
1. Excessive sick leave.	<input type="checkbox"/>				
2. Excessive tardiness.	<input type="checkbox"/>				
3. Patterned absences (freq. absent Mondays/Fridays)	<input type="checkbox"/>				
4. Frequent unscheduled absences without medical reason.	<input type="checkbox"/>				
5. Unauthorized absences.	<input type="checkbox"/>				
6. Significant accident rates.	<input type="checkbox"/>				
7. Wide swings in morale/mood.	<input type="checkbox"/>				
8. Difficulty in recognizing own mistakes.	<input type="checkbox"/>				
9. Makes mistakes due to inattention or poor judgment.	<input type="checkbox"/>				
10. Misses deadlines.	<input type="checkbox"/>				
11. Increasing difficulty in handling complex assignments.	<input type="checkbox"/>				
12. Complaints from customers.	<input type="checkbox"/>				
13. Complaints from co-workers.	<input type="checkbox"/>				
14. Overreacts to real or imagined criticism.	<input type="checkbox"/>				
15. Requires excessive or increased supervision.	<input type="checkbox"/>				

BEST CARE EMPLOYEE ASSISTANCE PROGRAM
Authorization to Release Information
From/To Best Care Employee Assistance Program

I, _____, authorize
(Name of Best Care EAP Client)

Best Care Employee Assistance Program to disclose to and receive information from:

_____ Employer/Human Resources/Supervisor _____
_____ Referral Resource _____
_____ Treatment Provider _____
_____ Other (please specify) _____

The following information (check appropriate area):

_____ Attendance Only
_____ Attendance, Assessment, Recommendations, and Compliance
_____ Substance Use, Abuse, and Chemical Dependency Information
_____ Psychological or Psychiatric Information
_____ Re-release of information (please specify) _____
_____ All Available Information
_____ Other (please specify) _____

For the following purpose:

_____ To monitor counseling and/or substance abuse treatment progress related to EAP referral.
_____ To provide counseling related information for EAP clients referred for specialized or long-term counseling or for substance abuse treatment.
_____ Other (please specify) _____

I understand I may revoke this authorization at any time by submitting a written request to a Best Care EAP Supervisor of Clinical Services or the Manager of Clinical Services. Information released according to the authorization may be subject to redisclosure by the recipient and may no longer be protected by privacy regulations. Release of information will cease upon receipt of written revocation. I understand such revocation will not apply to information that may have been released prior to written revocation. Upon fulfillment of the above stated purpose(s), this authorization will automatically expire one hundred eighty days from the date signed, or on _____ as I have requested, to fulfill the purposes of this authorization, unless sooner revoked.

DATE CLIENT

DATE WITNESS