TriHealth EAP Management Referral Form

Please send this form to: TriHealthEAP-as@trihealth.com or fax to 513-487-4358

TriHealth EAP Team Member that took call: ________________________ Date of call: ________________

Company Name: ____ _______

Appointment Date:________ Time:__________ Location: _________ Counselor:_____________________

☐ Mandatory Referral ☐ FFD** ☐ SAP ☐ DOT SAP CDL# ________________________

Referring/Billing Contact:________________________ Position Title: ___________________________ __

Phone:________________ Email:____

Bill Responsibility: ☐ Company ☐ Employee (must bring payment to session) Cost: ___________

Company Address: ____

Employee:_______________________________ Job Level:__________ Department: _________________

Employee Address: ____ __

Phone: ______________________ DOB:___________________ DOH:_____________________________

Employee's Email: ____

Manager Name:_______________________________________ Phone: __________________________

Email:____

Statement of the Problem:____

____

____

Is this a Fit for Duty?** Examples: suicidal comments, threats to others, verbal/physical aggression, extremely unusual behavior. Yes ☐ No ☐

**** Only an independent Psychiatrist, Licensed Psychologist or Physician may determine fitness for duty.*

Will the company authorize an IME at the company's expense? ☐ Yes ☐ No

Will the company approve TriHealth EAP to facilitate a drug screen at the company's expense? ☐ Yes ☐ No

Company does not approve drug screen. ☐ Yes ☐ No

Drug Screen Results

Date of Test: ______________ Facility: ____

Type of Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion ☐ Post Accident

Positive: ☐ Yes ☐ No Refusal to Test: ☐ Yes ☐ No Tampering/Dilution ☐ Yes ☐ No

Please note: Clients sent by TriHealth EAP to participate in a drug screen as part of their assessment will be required to remain at the testing site and participate in a witnessed follow-up screen if their first specimen temperature is out of range.

Please rate the following areas on a scale of 1-5. 1= Not a Problem, 5= Very Serious Problem

Not a Problem Very Serious Problem

Behavior	**1**	**2**	**3**	**4**	**5**
Absenteeism/Tardiness					
Quality of Work					
Quantity of Work					
Unacceptable Attitude/Behavior					
Safety					
Acceptance of Supervisor					
Interpersonal Relationships					

Comments: ____

____

____

Past disciplinary issues (Please attach additional documentation as needed):______________________________

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____

Is the employee's job in jeopardy? ☐ Yes ☐ No

Is this employee currently in a phase of your disciplinary process, suspended, or being terminated? ☐ Yes ☐ No

Comments: ____

____

Is there a Performance Improvement Plan being developed for this employee? ☐ Yes ☐ No

Will the employee be removed from the workplace? ☐ Yes ☐ No

Date removed:________________ For how long?________________

What specific behaviors/goals/improvements do you wish to see from this employee? (please include additional written documentation or details and timeframe).

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What are the consequences if the employee does not demonstrate improvement? ______________________

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Authorization for Use or Disclosure of Protected Health Information

I, the undersigned, hereby authorize Bethesda Healthcare, Inc., d.b.a., TriHealth EAP to disclose the specified individually identifiable health information to and/or obtain information from the person/organization listed below. This authorization includes release of information concerning treatment of drug or alcohol abuse, drug-related conditions, alcohol dependence, and/or psychiatric / psychological conditions and HIV related conditions. The following information may be released:

☐ Assessment ☐ Treatment Plan/Progress ☐ Recommendations ☐ Diagnosis ☐ Review of Records

☐ Other:___________________

Name	Position	Phone #	Email

This information is being released for use for the following purpose:____

I understand that the information used and/or disclosed pursuant to this Authorization may be re-disclosed by the recipient of the information and may no longer be protected by Federal law. However, if the information disclosed pursuant to this Authorization includes alcohol or drug treatment records, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit such person(s) from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the patient to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. If the information disclosed pursuant to this Authorization includes the identity of an individual on whom an HIV test is performed, HIV test results or AIDS-related treatment information, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from confidential records protected from disclosure by Ohio law. Ohio law prohibits such person(s) from making any further disclosure of this information without the specific, written, and informed release of the patient to whom it pertains, or as otherwise permitted by Ohio law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses.

This statement must be signed and dated and may be revoked at any time except to the extent action has been taken prior to revocation in reliance upon the authorization. This consent will expire ninety (90) days after the date of my signature below unless otherwise stated on the line below.

______________________(specify date, event or condition upon which it will expire)

I acknowledge that TriHealth EAP has the right to and will condition the performance of services to me on whether or not this Authorization is signed, if the purpose of such services is solely to create information for disclosure to the above named third party (such as my employer).
I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the above-identified records for the purpose and extent stated above.

______________________	______________________	____________
Print Client Name	Client/Guardian Signature	Date
______________________	______________________	____________
Print Witness Name	Witness Signature	Date