Family Service of the Chautauqua Region
332 East Fourth Street, Jamestown, NY 14701 (716) 488-1971 fax (716) 483-6878
Email: familyservice@fscr.mygbiz.com

Date: ____________________

EAP MANDATED REFERRAL

Company: ____ **Phone:** ____________

Name of Supervisor making referral: ____

Company contact person(s) for status report: ____
We are limited to reporting to only the persons names above

Who will be setting up appointment date/time? **Supervisor** ____ **Employee** ____

Name of Employee: ______________________________ **Position:** ___________________________

Presenting Problem:

____
____
____
____

Objective:

____
____

Has employee been suspended from work: **Yes** ____ **No** ____

Is there any suspicion of: **Drug Abuse** **Yes** ____ **No** ____

Alcohol Abuse **Yes** ____ **No** ____

Please fax this form with employees' signature to:
Family Service at (716) 483-6878
Please mail hard copy to address shown below.

It is our policy to report only that the employee is/is not attending EAP sessions and is/is not following through with recommended treatment. If further information is required it can only be reported with the written consent of the employee.

See reverse side for Consent for Release of Information
No information can be reported without the employee's signature.

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RELEASE OF INFORMATION

Date: ____________________ **Expiration Date:** ____________________
12 months after inception

Employee's Name: ____

I hereby authorize my EAP provider to release and receive information regarding my attendance and cooperation to:

Company/Organization Name: ____

I understand that the information shared with my employer will be minimal. If anything further is required, it will be with my understanding and consent. I also understand that I can withdraw this Consent for Release of Information at anytime.

____ ________________________
Employee's Signature **Date**

____ ________________________
Referring Supervisor's Signature **Date**