

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:

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Objective:

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Has employee been suspended from work: Yes \_\_\_\_ No \_\_\_\_

Is there any suspicion of:            Drug Abuse    Yes \_\_\_\_ No \_\_\_\_  
   Alcohol Abuse    Yes \_\_\_\_ No \_\_\_\_

**Please fax both sides of 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.**



United Way Member

Family Service of the Chautauqua Region, Inc.  
332 East Fourth Street. PO Box 457, Jamestown, NY 14701  
Ph: (716) 488-1971 Fax: (716) 483-6878

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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**