EAP CLINICAL ASSESSMENT FORM

To be completed on every EAP referral.

Client Name	**Date of Assessment**	**Date of Birth**	**Social Security #**
Employee Name	**Employer**		**Occupation**
Provider Name (print)	**EAP Authorization #:**		
☐ self ☐ employer * ☐ other:	☐ YES ☐ NO	**Signed EAP Statement of Understanding**	
Referral Source	**(*Complete Management Referral section - see Provider Guide for definition of terms)**		
Presenting Problem			
Client's Expected Outcome			

Clinical Assessment

Previous Treatment: **Mental Health Inpatient or Outpatient Treatment**

Level of Care Inpatient or Outpatient Program Completed (dates):	**Provider/Treatment Program:**

Current Signs/Symptoms

☐ YES	☐ NO	Acute Stress Disorder	☐ YES	☐ NO	Pressured Speech	☐ YES	☐ NO	Loose Associations
☐ YES	☐ NO	Depressed Mood	☐ YES	☐ NO	Weight Loss/Gain	☐ YES	☐ NO	Psychomotor Retardation
☐ YES	☐ NO	Appetite Disturbance	☐ YES	☐ NO	Panic Attacks	☐ YES	☐ NO	Concentration/Attention Problems
☐ YES	☐ NO	Sleep Disturbance	☐ YES	☐ NO	Phobias	☐ YES	☐ NO	Impulse Control Problems
☐ YES	☐ NO	Low Energy	☐ YES	☐ NO	Obsessions/Compulsions	☐ YES	☐ NO	Conduct Problems
☐ YES	☐ NO	Agitation	☐ YES	☐ NO	Binging/Purging	☐ YES	☐ NO	Oppositional Behaviors
☐ YES	☐ NO	Labile	☐ YES	☐ NO	Anorexia	☐ YES	☐ NO	Sexual Dysfunction
☐ YES	☐ NO	Irritability	☐ YES	☐ NO	Paranoid Ideation	☐ YES	☐ NO	
☐ YES	☐ NO	Generalized Anxiety	☐ YES	☐ NO	Circumstantial/Tangential			Other

Mental Status

☐ YES	☐ NO	Oriented x3	☐ YES	☐ NO	Impaired Memory	☐ YES	☐ NO	Delusions
☐ YES	☐ NO	Impaired Judgment	☐ YES	☐ NO	Other Cognitive Impairment	☐ YES	☐ NO	Hallucinations

Affect/Appearance:

Risk Assessment: (Explain any positive findings)

	SUICIDAL RISK:		HOMICIDAL RISK:		ABUSE RISK:
☐ YES ☐ NO	Ideation	☐ YES ☐ NO	Ideation	☐ YES ☐ NO	Verbal
☐ YES ☐ NO	Intent	☐ YES ☐ NO	Intent	☐ YES ☐ NO	Emotional
☐ YES ☐ NO	Plan	☐ YES ☐ NO	Plan	☐ YES ☐ NO	Physical
☐ YES ☐ NO	Means	☐ YES ☐ NO	Means	☐ YES ☐ NO	Sexual
		☐ YES ☐ NO	Attempt		

COMMENTS:

Substance Use Assessment (including alcohol, tobacco & illicit, prescribed and over-the-counter drugs)

☐ YES ☐ NO	History of substance use treatment inpatient/outpatient	If YES:	
		Level of Care	**Dates Tx**
☐ YES ☐ NO	Drug/Alcohol/Tobacco Use (For Past 12 Months) If YES complete the following:		

Substance	Amount	Frequency	Age Began	Last Used

☐ YES ☐ NO	Family history of substance use If YES complete the following for current primary relationships			
Substance	**Amount**	**Frequency**	**Age Began**	**Last Used**

Substance Use Assessment (continued) - Current Signs/Symptoms:	
☐ YES ☐ NO	Consumed Alcohol or Used Drugs More Than Intended
☐ YES ☐ NO	Neglected Usual Responsibilities Because of Using Alcohol or Drugs
☐ YES ☐ NO	Wanted/Needed to Cut Down Alcohol or Drug Use in the Last Year
☐ YES ☐ NO	Longest Period of Sobriety:
☐ YES ☐ NO	Withdrawal Symptoms (Trembling, Agitation, Sleep Problems, Nausea)
☐ YES ☐ NO	Support System Concerned About Drinking or Drug Use
☐ YES ☐ NO	Preoccupation with Alcohol or Drug Use
☐ YES ☐ NO	Use of Alcohol or Drugs to Relieve Emotional Discomfort Such As Sadness, Anger or Boredom
☐ YES ☐ NO	Experienced Physical Discomfort Following Substance Use, or the Day After Substance Use
☐ YES ☐ NO	Increased Tolerance to Alcohol or Drugs
☐ YES ☐ NO	Continued Use Despite Negative Life Consequences (Legal, Workplace, Relational)
☐ YES ☐ NO	Evidenced Physical/Medical Symptoms Related to Drug/Alcohol Use
☐ YES ☐ NO	Minimization/Inconsistency in Reporting Use Patterns
	Collateral Information:

Medical Information:		
Name of PCP	**Last Visit to MD (date)**	**Medical Conditions**
Medications & Dosages		
☐ YES ☐ NO	Is Medical Condition Related to Presenting Problem	

Management Referral (you must communicate with the assigned Employee Assistance Consultant)		
	☐ On the Job ☐ On Leave*	
Job Title	**Current Job Status**	**Type of Leave**
EAC's Name		**Phone**

Reason for Referral Per CBH EAC on Case

☐	Absenteeism	☐	Hygiene
☐	Tardiness	☐	Transfers or Demotions
☐	Safety Issues/Accident	☐	Work Performance
☐	Self-Report – Substance Abuse	☐	Problem Behavior
☐	Positive Drug Screen	☐	Anger Management
☐	Productivity Issues	☐	Policy Violation (i.e. Sexual Harassment, Workplace Violence)
☐	Conflict with Co-Workers/Supervisor	☐	Other:
☐	Customer Complaint		

Consequences of Job Issue

Provider's Plan to Address Workplace Issues

Suggestions for Workplace

Problem Areas				Strengths/Resources	
☐	Spouse/Partner	☐	Access to Healthcare	☐	Family Support
☐	Family Concern -	☐	Gambling	☐	Relationship Stability
☐	☐SA ☐ MH ☐ Other:	☐	Acute Stress	☐	Intellectual Cognitive Skills
☐	Child/Adolescent	☐	Psychological/Emotional	☐	Coping Skills/Resiliency
☐	Peers	☐	Anger Management	☐	Insight
☐	Work Performance	☐	School Performance	☐	Parenting Skills
☐	Legal	☐	Substance Use	☐	Socio-Economic Stability
☐	Financial	☐	Other:	☐	Communication Skills
☐	Housing			☐	Community Support
☐	Transportation			☐	Spirituality/Religious Affiliations
				☐	Other:

DSM IV Diagnosis (Complete If Clinically Supported)

Axis I – Code(s) & Disorder(s)

Axis II – Code(s) & Disorder(s)

Axis III – Relevant Medical Conditions
Axis IV – Psychosocial Stressors
Axis V – GAF Score
☐ YES ☐ NO **Treatment Plan Documented**

Recommendations of EAP Assessment:			
EAP Dates of Service			
Recommendations for Ongoing Services	☐ **NO**	☐ Resolved by EAP ☐Client Did Not Complete the EAP Assessment Process	
	☐**YES**	☐ Recommended the Following Referrals:	

If YES, *check all that apply:*

	Mental Health:		Substance Abuse:		Other:
☐	Inpatient	☐	Inpatient	☐	Medical
☐	Outpatient	☐	Intensive Outpatient (IOP)	☐	Self-Help
☐	Psychiatric Evaluation	☐	Low Intensive Outpatient (LIOP)	☐	Community Resources
☐	Other:	☐	Outpatient	☐	Financial (refer client back to CBH)
		☐	Education	☐	Legal (refer client back to CBH)
		☐	Other:	☐	Childcare/Eldercare (refer client back to CBH)

Client(s) Referred to:

Name	**Clinic/Agency**			
Address	**City**	**State**	**Zip**	**Phone**

CBH requires you to facilitate the referral for the client. Please check all steps completed.	
☐ Insurance checked/verified	☐ Referred to an in-network provider
☐ Treatment pre-certified with insurance	☐ Assessment information provided to referral resource
☐ Follow-up with client to determine satisfaction with referral	☐ Coordination of care with relevant medical and/or behavioral health providers

Post-EAP Follow-up
☐ Client followed through with recommendation(s)
☐ Client did not follow through with recommendation(s)
☐ Follow-up attempted, no response from client
☐ Refused referral
For Management Referrals (additional information):

EAP providers are required to obtain a Release of Information to referral in order to verify attendance at the initial appointment.			
EAP provider must call EAC with verification of attendance		*800-241-4057x*	
	EAC Name		**EAC Extension**
	Date Faxed		

Provider Name (Please Print)	**Degree/License**
Signature	**Date**

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