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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*):	☐ Self ☐ Employer* ☐ Other: ______	EAP Code:

Signed EAP Statement of Understanding: ☐ Yes ☐ No	Referral Source):	**(*Complete Management Referral section • See Provider Guide for definition of terms)**

Presenting Problem:

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 Psvchomotor 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	Other: ______
☐ Yes ☐ No Generalized Anxiety	☐ Yes ☐ No Circumstantial/Tangential	______

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:

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Current Signs/Symptoms *(Continued)*

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

Substance Use Assessment

☐ 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 lo 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:	
Is medical condition related to presenting problem? ☐ Yes ☐ No	

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:	

EAP CLINICAL ASSESSMENT FORM *(Continued)*

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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.		☐ Spiritual/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:

Treatment Plan Documented: ☐ **Yes** ☐ **No**

EAP CLINICAL ASSESSMENT FORM *(Continued)*

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Recommendations of EAP Assessment

EAP dates of service: ____________________

Recommendations for Ongoing Services: ☐ Yes ☐ No ☐ Resolved by EAP ☐ Client did not complete the EAP assessment process

☐ Recommended the following referrals: ____________________

If YES, *check all that apply:*

MENTAL HEALTH:	SUBSTANCE USE:	OTHER:
☐ Inpatient	☐ Inpatient	☐ Medical
☐ Outpatient	☐ Intensive Outpatient (IOP)	☐ Self-Help
☐ Psychiatric Evaluation	☐ Low Intensive Outpatient (LIOP)	☐ Community Resources
☐ Anger Management	☐ Outpatient	☐ Financial *(refer client back to EBH)*
☐ Other: ____________________	☐ Education	☐ Legal *(refer client back to EBH)*
	☐ Other: ____________________	☐ Childcare/Eldercare *(refer client back to EBH)*

Client(s) Referred to:

Name:	Clinic/Agency:		Phone:
Address:	City:	State:	Zip Code:

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 <u>must</u> call EAC with verification of attendance 800.241.4057

EAC Name:	EAC Extension:	Date Faxed:

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

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