

## EAP CLINICAL ASSESSMENT FORM

*To be completed on every EAP referral.*

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

<b>Clinical Assessment</b>					
<b>Previous Treatment: Mental Health Inpatient or Outpatient Treatment</b>					
<b>Level of Care Inpatient or Outpatient Program Completed (dates):</b>			<b>Provider/Treatment Program:</b>		
<b>Current Signs/Symptoms</b>					
<input type="checkbox"/> YES <input type="checkbox"/> NO	Acute Stress Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pressured Speech	<input type="checkbox"/> YES <input type="checkbox"/> NO	Loose Associations
<input type="checkbox"/> YES <input type="checkbox"/> NO	Depressed Mood	<input type="checkbox"/> YES <input type="checkbox"/> NO	Weight Loss/Gain	<input type="checkbox"/> YES <input type="checkbox"/> NO	Psychomotor Retardation
<input type="checkbox"/> YES <input type="checkbox"/> NO	Appetite Disturbance	<input type="checkbox"/> YES <input type="checkbox"/> NO	Panic Attacks	<input type="checkbox"/> YES <input type="checkbox"/> NO	Concentration/Attention Problems
<input type="checkbox"/> YES <input type="checkbox"/> NO	Sleep Disturbance	<input type="checkbox"/> YES <input type="checkbox"/> NO	Phobias	<input type="checkbox"/> YES <input type="checkbox"/> NO	Impulse Control Problems
<input type="checkbox"/> YES <input type="checkbox"/> NO	Low Energy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Obsessions/Compulsions	<input type="checkbox"/> YES <input type="checkbox"/> NO	Conduct Problems
<input type="checkbox"/> YES <input type="checkbox"/> NO	Agitation	<input type="checkbox"/> YES <input type="checkbox"/> NO	Binging/Purging	<input type="checkbox"/> YES <input type="checkbox"/> NO	Oppositional Behaviors
<input type="checkbox"/> YES <input type="checkbox"/> NO	Labile	<input type="checkbox"/> YES <input type="checkbox"/> NO	Anorexia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sexual Dysfunction
<input type="checkbox"/> YES <input type="checkbox"/> NO	Irritability	<input type="checkbox"/> YES <input type="checkbox"/> NO	Paranoid Ideation	<input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Generalized Anxiety	<input type="checkbox"/> YES <input type="checkbox"/> NO	Circumstantial/Tangential		Other
<b>Mental Status</b>					
<input type="checkbox"/> YES <input type="checkbox"/> NO	Oriented x3	<input type="checkbox"/> YES <input type="checkbox"/> NO	Impaired Memory	<input type="checkbox"/> YES <input type="checkbox"/> NO	Delusions
<input type="checkbox"/> YES <input type="checkbox"/> NO	Impaired Judgment	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other Cognitive Impairment	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hallucinations
<b>Affect/Appearance:</b>					
<b>Risk Assessment: (Explain any positive findings)</b>					
<b>SUICIDAL RISK:</b>		<b>HOMICIDAL RISK:</b>		<b>ABUSE RISK:</b>	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Ideation	<input type="checkbox"/> YES <input type="checkbox"/> NO	Ideation	<input type="checkbox"/> YES <input type="checkbox"/> NO	Verbal
<input type="checkbox"/> YES <input type="checkbox"/> NO	Intent	<input type="checkbox"/> YES <input type="checkbox"/> NO	Intent	<input type="checkbox"/> YES <input type="checkbox"/> NO	Emotional
<input type="checkbox"/> YES <input type="checkbox"/> NO	Plan	<input type="checkbox"/> YES <input type="checkbox"/> NO	Plan	<input type="checkbox"/> YES <input type="checkbox"/> NO	Physical
<input type="checkbox"/> YES <input type="checkbox"/> NO	Means	<input type="checkbox"/> YES <input type="checkbox"/> NO	Means	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sexual
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	Attempt		
<b>COMMENTS:</b>					

<b>Substance Use Assessment (including alcohol, tobacco &amp; illicit, prescribed and over-the-counter drugs)</b>					
<input type="checkbox"/> YES <input type="checkbox"/> NO		History of substance use treatment inpatient/outpatient		If YES:	
				<b>Level of Care</b>	<b>Dates Tx</b>
<input type="checkbox"/> YES <input type="checkbox"/> NO		Drug/Alcohol/Tobacco Use (For Past 12 Months) If YES complete the following:			
<b>Substance</b>	<b>Amount</b>	<b>Frequency</b>	<b>Age Began</b>	<b>Last Used</b>	
<input type="checkbox"/> YES <input type="checkbox"/> NO		Family history of substance use If YES complete the following for current primary relationships			
<b>Substance</b>	<b>Amount</b>	<b>Frequency</b>	<b>Age Began</b>	<b>Last Used</b>	

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

<b>Medical Information:</b>		
<b>Name of PCP</b>	<b>Last Visit to MD (date)</b>	<b>Medical Conditions</b>
<b>Medications &amp; Dosages</b>		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Is Medical Condition Related to Presenting Problem	

<b>Management Referral (you must communicate with the assigned Employee Assistance Consultant)</b>		
		<input type="checkbox"/> On the Job <input type="checkbox"/> On Leave*
<b>Job Title</b>	<b>Current Job Status</b>	<b>Type of Leave</b>
<b>EAC's Name</b>		<b>Phone</b>
<b>Reason for Referral Per CBH EAC on Case</b>		
<input type="checkbox"/> Absenteeism	<input type="checkbox"/> Hygiene	
<input type="checkbox"/> Tardiness	<input type="checkbox"/> Transfers or Demotions	
<input type="checkbox"/> Safety Issues/Accident	<input type="checkbox"/> Work Performance	
<input type="checkbox"/> Self-Report – Substance Abuse	<input type="checkbox"/> Problem Behavior	
<input type="checkbox"/> Positive Drug Screen	<input type="checkbox"/> Anger Management	
<input type="checkbox"/> Productivity Issues	<input type="checkbox"/> Policy Violation (i.e. Sexual Harassment, Workplace Violence)	
<input type="checkbox"/> Conflict with Co-Workers/Supervisor	<input type="checkbox"/> Other:	
<input type="checkbox"/> Customer Complaint		

<b>Consequences of Job Issue</b>

<b>Provider's Plan to Address Workplace Issues</b>

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

<b>DSM IV Diagnosis (Complete If Clinically Supported)</b>
<b>Axis I – Code(s) &amp; Disorder(s)</b>
<b>Axis II – Code(s) &amp; Disorder(s)</b>



<b>Axis III – Relevant Medical Conditions</b>	
<b>Axis IV – Psychosocial Stressors</b>	
<b>Axis V – GAF Score</b>	
<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Treatment Plan Documented</b>

<b>Recommendations of EAP Assessment:</b>			
<b>EAP Dates of Service</b>			
<b>Recommendations for Ongoing Services</b>		<input type="checkbox"/> NO	<input type="checkbox"/> Resolved by EAP <input type="checkbox"/> Client Did Not Complete the EAP Assessment Process
		<input type="checkbox"/> YES	<input type="checkbox"/> Recommended the Following Referrals:
<b>If YES, check all that apply:</b>			
	<b>Mental Health:</b>		<b>Substance Abuse:</b>
<input type="checkbox"/>	Inpatient	<input type="checkbox"/>	Inpatient
<input type="checkbox"/>	Outpatient	<input type="checkbox"/>	Intensive Outpatient (IOP)
<input type="checkbox"/>	Psychiatric Evaluation	<input type="checkbox"/>	Low Intensive Outpatient (LIOP)
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Outpatient
		<input type="checkbox"/>	Education
		<input type="checkbox"/>	Other:
			<b>Other:</b>
		<input type="checkbox"/>	Medical
		<input type="checkbox"/>	Self-Help
		<input type="checkbox"/>	Community Resources
		<input type="checkbox"/>	Financial (refer client back to CBH)
		<input type="checkbox"/>	Legal (refer client back to CBH)
		<input type="checkbox"/>	Childcare/Eldercare (refer client back to CBH)

<b>Client(s) Referred to:</b>				
<b>Name</b>		<b>Clinic/Agency</b>		
<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>	<b>Phone</b>

<b>CBH requires you to facilitate the referral for the client. Please check all steps completed.</b>			
<input type="checkbox"/>	Insurance checked/verified	<input type="checkbox"/>	Referred to an in-network provider
<input type="checkbox"/>	Treatment pre-certified with insurance	<input type="checkbox"/>	Assessment information provided to referral resource
<input type="checkbox"/>	Follow-up with client to determine satisfaction with referral	<input type="checkbox"/>	Coordination of care with relevant medical and/or behavioral health providers
<b>Post-EAP Follow-up</b>			
<input type="checkbox"/>	Client followed through with recommendation(s)		
<input type="checkbox"/>	Client did not follow through with recommendation(s)		
<input type="checkbox"/>	Follow-up attempted, no response from client		
<input type="checkbox"/>	Refused referral		
<b>For Management Referrals (additional information):</b>			

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		<b>EAC Name</b>	<b>EAC Extension</b>
		800-241-4057x	
		<b>Date Faxed</b>	

<b>Provider Name (Please Print)</b>	<b>Degree/License</b>
<b>Signature</b>	<b>Date</b>