Family Counseling Service EAP - Mandatory Referral Form

(To be completed by the referring person representing organizational leadership.)

Please fax the completed (page 1) Referral Form and (page 2) Authorization Form to FCS at 205.345.4842

Today's Date: _____/_____/_____

Employee's Name: _____ Title: _____

Employee's Phone#: _____

Referring Person: _____ Title: _____

Referring Person's Phone#: _____

Organization's Name: _____

REASON FOR THIS REFERRAL TO EAP: *(Check all that apply)*

[ ] Conduct: ***(Check all that apply)***

___ *Quality of Work*	___ *Dependability*	___ *Judgment*
___ *Communication*	___ *Relationships*	___ *Organization*
___ *Motivation*	___ *Reaction to Stress*	___ *Problem Solving*
___ *Compliance*	___ *Acceptance of Supervision*	___ Other: _____

[ ] Substance Abuse ***(Please list substance)***

1. Was there a positive alcohol/drug test? [ ] Yes [ ] No
2. Does the employee's role fall under DOT (Department of Transportation) guidelines? [ ] Yes [ ] No

DESCRIBE PROBLEM BEHAVIOR:

_____

_____

_____

EXPECTATIONS FOR CHANGE:

_____

_____

DATE BY WHICH EMPLOYEE MUST CONTACT EAP: _____

CONSEQUENCES IF JOB PERFORMANCE DOES NOT IMPROVE: ***(Please check one)***

[ ] No Consequences ( ] Corrective Action [ ] Suspension [ ] Termination

Family Counseling Service EAP	2020 Paul W. Bryant Drive, Tuscaloosa, AL
For an appointment call the FCS office at 205.752.2504	Office hours: 8:30 am – 5:00 pm Monday-Friday

FAMILY COUNSELING SERVICE
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Employee Name: _____ DOB: _____

Address: _____

City, State, Zip: _____Phone: _____

I authorize Family Counseling Service (2020 Paul W. Bryant Drive, Tuscaloosa, AL) and its staff to (1) use/receive the following protected health information from, and/or (2) disclose the following protected health information to:

Supervisor's Name: _____

Name of Human Resource Personnel: _____

Employer/Company Name: _____

Address: _____

City, State, Zip: _____Phone: _____

Description of protected health information to be used or disclosed:

- Whether I have contacted Family Counseling Service and date of appointments.
- Whether I am attending appointments and complying with Family Counseling Service recommendations.
- Recommendations for my employer that will support me in making the required improvements.
- Date that this mandatory referral is being closed and any final recommendations from Family Counseling Service.
- Other, please specify:

_____

This authorization shall be in effect for one year from the date it is signed, or until (whichever comes first):

_____ the following date: _____ or

_____ the purposes for the use or disclosure described above are satisfied or terminated.

at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Family Counseling Service at 2020 Paul W. Bryant Drive, Tuscaloosa, Alabama 35401. I understand that a revocation is not effective to the extent that Family Counseling Service has relied on this authorization and acted upon it.

Family Counseling Service will not condition providing services to me on whether I provide authorization for the requested use or disclosure except that (1) such use or disclosure is considered to be part of common ethical practice, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I understand that any alcohol/drug treatment records are protected under the Federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42, C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R, Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

_____ _____

Employee Signature Date