

**CONFIDENTIAL**  
**EAP SUPERVISORY REFERRAL FORM**

The purpose of this form is to provide information to the Employee Assistance Program (EAP) regarding an employee's poor work performance when there is reason to believe that the cause may be due to a personal/medical problem. **THIS FORM AND ALL SUPPORTING DOCUMENTATION MUST BE SUBMITTED TO THE EAP IN DUPLICATE. IF DOCUMENTATION DOES NOT EXIST, PLEASE PROVIDE A SYNOPSIS EXPLAINING THE BASIS FOR REFERRAL. DO NOT SUBMIT WITHOUT ONE OR THE OTHER.**

(Please print in ink, or type) REFERRAL DATE \_\_\_\_\_

EMPLOYEE'S NAME \_\_\_\_\_ SS# \_\_\_\_\_  
(Please circle: Mr./Mrs./Ms.)

ADDRESS \_\_\_\_\_ HOME PH. \_\_\_\_\_  
(City/County, State, Zip Code)

CLASSIFICATION \_\_\_\_\_ WK. PH. \_\_\_\_\_

GRADE \_\_\_\_\_ EOD \_\_\_\_\_ DOB \_\_\_\_\_ CELL PH. \_\_\_\_\_

DEPARTMENT/AGENCY NAME \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_  
(Zip Code)

WORK HOURS/SHIFT \_\_\_\_\_ DAYS OFF \_\_\_\_\_  
(Please use *non-military* time)

REFERRED BY \_\_\_\_\_ TITLE \_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

AGENCY EAP REPRESENTATIVE \_\_\_\_\_ PH. \_\_\_\_\_

TITLE \_\_\_\_\_ FAX \_\_\_\_\_

\_\_\_\_\_ Mailing Address \_\_\_\_\_  
AGENCY EAP REPRESENTATIVE'S SIGNATURE \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**REASON FOR REFERRAL**

*First, check off which type of referral this is. Next, check off the corresponding areas that are relevant to this referral; then attach documentation or synopsis supporting areas checked and overall reason for this referral. This is a:*

**I.  SUBSTANCE ABUSE REFERRAL**

**VIOLATION OF GOVERNOR'S EXECUTIVE ORDER REGARDING SUBSTANCE ABUSE:**

\_\_\_\_\_ Failed random drug test \_\_\_\_\_ Alcohol related conviction  
\_\_\_\_\_ Other \_\_\_\_\_

**II.  MENTAL HEALTH REFERRAL**

**ATTENDANCE** (Please place numbers where numbers are requested):

\_\_\_\_\_ Number of days absent past 12 mos. \_\_\_\_\_ Number of extended lunches  
past 6 mos.  
\_\_\_\_\_ Pattern (e.g., Mondays, Fridays, after paydays, \_\_\_\_\_ Number of times late past 6 mos.  
before and after holidays) \_\_\_\_\_ Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**JOB PERFORMANCE** (This area must be impacted for referral eligibility, with supporting documentation attached for items checked):

- Lower quality of work
- Decreased productivity
- Increased errors
- Impaired judgment/memory
- Erratic work patterns
- Failure to meet schedules
- Inability to concentrate
- Other \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**BEHAVIOR DEMONSTRATED WITH RESPECT TO JOB PERFORMANCE:**

- Avoids supervisors/coworkers
- Less communicative
- Unusually sensitive to advice/constructive criticism
- Unusually critical of supervisor/coworkers/employer
- Loss of interest
- Frequent mood swings
- Disregard for safety
- Other \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**DOMESTIC VIOLENCE:** \_\_\_\_\_

Have the above issues been discussed with employee? (Yes)\_\_\_\_\_ (No)\_\_\_\_\_

Has employee been referred to State Medical Director? (Yes)\_\_\_\_\_ (No)\_\_\_\_\_

If yes, when? (Please attach relevant documents) \_\_\_\_\_

**IF EMPLOYEE INTENDS TO PARTICIPATE, THIS REFERRAL CANNOT BE PROCESSED WITHOUT "YES" INDICATED BELOW AND EMPLOYEE'S SIGNATURE**

*I understand that my employer is referring me to the State Employee Assistance Program. I also understand that my signature below does not reflect my agreement or disagreement with any of the issues raised. My signature verifies that I have seen this referral and all documentation contained therein.*

\_\_\_\_\_ YES, I will participate in the Employee Assistance Program. My health insurance carrier is: \_\_\_\_\_

\_\_\_\_\_ NO, I will not participate in the Employee Assistance program.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Your agency EAP Representative should forward this form and all supporting documentation IN DUPLICATE to:

**Maryland Department of Budget and Management  
Employee Relations Division  
Employee Assistance Program  
301 W. Preston Street, Room 607  
Baltimore, Maryland 21201**

**or Fax to: 410-333-7603**

**If you have questions, please contact the Employee Assistance Program at 410-767-5846.**

**FAILURE TO LEGIBLY AND FULLY COMPLETE THIS FORM WILL RESULT IN APPOINTMENT DELAY**