#  Appendix 3. EAP Supervisory Referral Form CONFIDENTIAL

**STATE OF MARYLAND - EAP SUPERVISORY REFERRAL FORM**

The purpose of this form is to provide information to the Employee Assistance Program (EAP) regarding an employee who may have a personal problem that may negatively impact (or has negatively impacted) their job performance. Additionally, please note that the EAP contractor will inform the State’s EAP Coordinator of each instance where an employee attends or fails to attend a scheduled EAP counseling session. **THIS FORM MUST BE SUBMITTED TO THE EAP COORDINATOR. IN THE SPACE PROVIDED PLEASE WRITE A BRIEF SYNOPSIS EXPLAINING THE BASIS FOR REFERRAL.**

Please print legibly in ink or type. REFERRAL DATE:

## COMPLETE EMPLOYEE INFORMATION BELOW:

EMPLOYEE’S NAME: W#:

GENDER:FEMALE MALE NON-BINARY/THIRD GENDER PREFER TO SELF-DESCRIBE PREFER NOT TO SAY

HOME ADDRESS:

(Address, City, State, and Zip Code)

HOME PHONE: WORK PHONE: CELL PHONE:

WORK EMAIL: PERSONAL EMAIL:

CLASSIFICATION: GRADE:

 START DATE:

DATE OF BIRTH:

MARITAL STATUS:

 DEPARTMENT/AGENCY NAME:

(Do not use acronyms)

WORK ADDRESS:

(Address, City, State and Zip Code)

WORK HOURS/SHIFT: DAYS OFF:

(Use 12-hour clock - DO NOT use military time)

## COMPLETE AGENCY CONTACT INFORMATION BELOW:

**SELECT REFERRAL TYPE: SUPERVISORY MANAGEMENT**

REFERRED BY: PHONE:

TITLE: FAX:

AGENCY EAP REPRESENTATIVE: PHONE:

TITLE: FAX:

AGENCY EAP REPRESENTATIVE EMAIL:

MAILING ADDRESS:

Agency EAP Representative (Print Name) Agency EAP Representative (Signature)

**REASON FOR REFERRAL**

**FORM COMPLETION STEPS**

#1: Select referral type.

#2: Select each applicable subcategory as it relates to the requested referral type.

#3: Attach all supporting documentation and/or provide a synopsis that supports referral type and corresponding subcategories.

## SUBSTANCE ABUSE REFERRAL

***VIOLATION OF GOVERNOR’S EXECUTIVE ORDER REGARDING SUBSTANCE ABUSE*: YES/NO (Circle One)**

 Failed random drug test

 Alcohol related conviction Other

## MENTAL HEALTH REFERRAL

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

 # of days absent in past 12 month # of extended lunches past six (6) months

 # of times late in past six (6) months Pattern (e.g., Mondays, Fridays, after paydays, before and

after holidays). Please describe:

 Other

**JOB PERFORMANCE** (Please provide supporting documentation for any items checked below):

 Lower quality of work

 Erratic work patterns

 Decreased productivity

 Failure to meet schedules

 Increased errors

 Inability to concentrate

 Impaired judgment/memory

 Other

## BEHAVIOR DEMONSTRATED WITH RESPECT TO JOB PERFORMANCE

 Avoids supervisors/coworkers Unusually sensitive to advice/constructive criticism

 Less communicative

 Unusually critical of supervisor/coworkers/employer

 Disregard for safety

 Frequent mood swings

 Loss of interest

 Other

## DOMESTIC VIOLENCE

**SYNOPSIS**

Have the above issues been discussed with employee? Yes/No (Circle One) Has employee been referred to State Medical Director? Yes/No (Circle One)

## IF EMPLOYEE INTENDS TO PARTICIPATE, THIS REFERRAL CANNOT BE PROCESSED WITHOUT “YES” INDICATED BELOW AND THE 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 and that I consent to and authorize the EAP Contractor to release my attendance, or lack thereof, and/or my compliance with the EAP Contractor’s recommendations, to the State EAP Coordinator, Contract Manager and DBM Employee Relations Officer for the sole purpose of auditing the EAP Contractor’s performance. The types of information that may be disclosed for the purpose of auditing Contractor performance are as follows: number of sessions per supervisor referral, location of EAP counseling sessions, timeliness of appointment scheduling, gender of employees, age ranges, marital status, agency, city of EAP counselor, and referral outcome. I understand this consent becomes effective on the date I sign it and will continue in effect for the duration of the contract term between the State Employee Assistance Program and EAP Contractor, including any optional years and retention periods I understand I have the right to revoke this authorization at any time, by following the revocation procedures described in the Notice of Privacy Practices. I understand that I am entitled to receive a copy of this authorization upon request.*  *I agree that a photocopy or facsimile copy of this signed form is as valid as an original signed copy. I understand that after this information is disclosed, federal law might not protect it, and the recipient may re-disclose it. I agree to release the above-named individual(s) or organization(s) and the EAP, the EAP counselor, and his/her designee from liability that may result from furnishing this information as authorized in this disclosure.*

 **YES**, I will participate in the Employee Assistance Program **NO,** I will not participate in the Employee Assistance Program Name of Health Insurance Carrier

Employee Signature Date

**Your agency EAP Representative will securely forward this form and all supporting documentation to:** **EAP.DBM@maryland.gov** **or 410-333-7603 (fax)**

**If you have questions, please contact the Employee Assistance Program at 410-767-5846 or 410-767-1314.**

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

**STATE EAP COORDINATOR ONLY**

## URGENT: Yes/No (Circle One) DATE:

**COMMENTS:**

**PRINT NAME: SIGNATURE:**