

ADMINISTRATIVE REFERRAL

I. REFERRAL INFORMATION

DATE: _____

Referral made by: _____ Title: _____

Work phone: _____ Pager: _____ Cell phone: _____

Relationship to the identified client: _____

II. IDENTIFIED CLIENT INFORMATION

(First Name) (Middle Name) (Last Name) (Sex) (Age)

Address _____ Home Phone: _____

(City) (State) (Zip Code) Work Phone: _____

S.S.N.: _____ - _____ - _____ Terminal Degree: _____

Occupation: _____ Division/School/Location: _____

Annual Income: _____ 8- 9,999 _____ 10-14,999 _____ 15-19,999
_____ 20-24,999 _____ 25-49,999 _____ 50-Over Health Insurance: _____

III. BACKGROUND INFORMATION

1. Has any disciplinary action taken place or is any pending? Yes No
2. Has the individual been reported to a professional board? Yes No
3. How would you rate the performance of this individual at this time? A. Outstanding B. Above Average C. Average D. Below Average E. Unacceptable
4. How many days has this individual missed during the last 3 months? A. None B. 1-5 C. 5-10 D. 11-15 E. 16 and over

IV. SERVICES REQUESTED (Please check all that apply)

- _____ A. Clinical / assessment / assistance
_____ B. Fitness for duty evaluation (*documentation indicates individual may be impaired*)
_____ C. Threat Assessment (*documentation indicates individual may pose a risk*)
_____ D. Drug testing (*Post-accident/reasonable suspicion, the drug/alcohol test must be performed within (8) hours of the incident.*)
_____ E. Other: _____

I _____ understand I am being formally referred to the C/EAP and / or drug testing program. As a condition of this referral, I will need to sign a release of information which allows administration to be informed of my participation and any / all necessary information in order to comply with the conditions of this referral. My signature below indicates my permission for C/EAP and / or drug testing program to contact and relay such information to administration. I understand should I refuse, or withdraw this permission, my case will be closed by C/EAP and / or the drug testing program, and administration will be informed of my choice not to participate. This could result in administrative action up to and including termination.

C/EAP / Drug Testing Program Appointment Date / Time: _____ Location: _____

Identified Client's Signature Title / position Date

Supervisor's/Faculty Member's Signature Title Date

Designated Authority's / Administrator's Signature Title Date

IV. REASONS FOR REFERRAL

PLEASE PLACE A CHECK IN THE SPACE NEXT TO BEHAVIOR OR SYMPTOMS OBSERVED

ATTENDANCE	
<input type="checkbox"/>	Excessive absenteeism
<input type="checkbox"/>	Unusual excuses for absence
<input type="checkbox"/>	Extended lunch periods
<input type="checkbox"/>	Early departures
<input type="checkbox"/>	Excessive lateness
<input type="checkbox"/>	Frequently leaves work-site
<input type="checkbox"/>	

PERFORMANCE	
<input type="checkbox"/>	Lower quality of work
<input type="checkbox"/>	Failure to meet deadlines
<input type="checkbox"/>	Decreased productivity
<input type="checkbox"/>	Impaired judgment/memory
<input type="checkbox"/>	Inability to concentrate
<input type="checkbox"/>	Increased errors
<input type="checkbox"/>	Erratic patterns

BEHAVIOR	
<input type="checkbox"/>	Avoids others
<input type="checkbox"/>	Loss of interest or enthusiasm
<input type="checkbox"/>	Less communicative
<input type="checkbox"/>	Sensitive to advise or constructive criticism
<input type="checkbox"/>	Disregard for safety
<input type="checkbox"/>	

GENERAL APPEARANCE	
<input type="checkbox"/>	Fighting
<input type="checkbox"/>	Suspicious
<input type="checkbox"/>	High
<input type="checkbox"/>	Guarded
<input type="checkbox"/>	Fearful
<input type="checkbox"/>	Crying
<input type="checkbox"/>	Angry
<input type="checkbox"/>	Irritable
<input type="checkbox"/>	Anxious
<input type="checkbox"/>	Mood Swings
<input type="checkbox"/>	Excited
<input type="checkbox"/>	Depressed
<input type="checkbox"/>	Sleepy
<input type="checkbox"/>	Distracted
<input type="checkbox"/>	Evasive
<input type="checkbox"/>	Indifferent
<input type="checkbox"/>	Polite
<input type="checkbox"/>	Calm
<input type="checkbox"/>	Cooperative
<input type="checkbox"/>	

GROOMING	
<input type="checkbox"/>	Bizarre
<input type="checkbox"/>	Dirty
<input type="checkbox"/>	Disheveled
<input type="checkbox"/>	Sloppy
<input type="checkbox"/>	Messy
<input type="checkbox"/>	Unkempt
<input type="checkbox"/>	Neat/acceptable

SPEECH	
<input type="checkbox"/>	Incoherent
<input type="checkbox"/>	Slurred
<input type="checkbox"/>	Slobbering
<input type="checkbox"/>	Loud
<input type="checkbox"/>	Rapid
<input type="checkbox"/>	Slow
<input type="checkbox"/>	Hesitant
<input type="checkbox"/>	Soft
<input type="checkbox"/>	Normal
<input type="checkbox"/>	Alcohol – like odor on breath

ABILITY TO STAND	
<input type="checkbox"/>	Unable to stand
<input type="checkbox"/>	Feet wide apart for balance
<input type="checkbox"/>	Leaning for balance
<input type="checkbox"/>	Rigid
<input type="checkbox"/>	Sagging
<input type="checkbox"/>	Swaying
<input type="checkbox"/>	No problem

ABILITY TO WALK	
<input type="checkbox"/>	Unable to walk
<input type="checkbox"/>	Falling
<input type="checkbox"/>	Staggering
<input type="checkbox"/>	Holding on for stability
<input type="checkbox"/>	Wobbling
<input type="checkbox"/>	Weaving
<input type="checkbox"/>	Swaying
<input type="checkbox"/>	No problem

ORIENTATION	
<input type="checkbox"/>	Knows time of day
<input type="checkbox"/>	Knows his / name
<input type="checkbox"/>	Knows where he / she is

ACTIONS	
<input type="checkbox"/>	Threatening
<input type="checkbox"/>	Profanity
<input type="checkbox"/>	Punching
<input type="checkbox"/>	Kicking

EYES	
<input type="checkbox"/>	Bloodshot
<input type="checkbox"/>	Watery
<input type="checkbox"/>	Droopy lids
<input type="checkbox"/>	Glassy eyed

FACE	
<input type="checkbox"/>	Flushed
<input type="checkbox"/>	Pale
<input type="checkbox"/>	Other

REASON FOR REFERRAL (Document specifics, date / location, who observed behavior / incident(s)), _____
