

## 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. Is or has any disciplinary action taken place 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. Fitness for duty evaluation (*documentation indicates individual may be impaired*)  
 B. Threat Assessment (*documentation indicates individual may pose a risk*)  
 C. Drug testing (*Post accident/reasonable suspicion, the drug/alcohol test must be performed within (8) hours of the incident.*)

PeopleSoft account number required for post accident/reasonable suspicion drug testing.

Account	Fund	Department	Program	Class	Project

D. Other: \_\_\_\_\_

I \_\_\_\_\_ understand I am being formally referred to the CAP 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 and all necessary information in order to comply with the conditions of this referral. My signature below indicates my permission for CAP 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 CAP and / or the drug testing program, and administration will be informed of my choice to not participate. This could result in administrative action up to and including termination.

CAP -Drug Testing Program Appointment Date / Time: \_\_\_\_\_ Location: \_\_\_\_\_

\_\_\_\_\_  
 Identified Client's Signature Title / position Date

\_\_\_\_\_  
 Supervisor/Faculty Member Signature Title Date

\_\_\_\_\_  
 Designated Authority's / Administrator Signature Title Date

**V. 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
<input type="checkbox"/>	

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
<input type="checkbox"/>	

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
<input type="checkbox"/>	

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
<input type="checkbox"/>	

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
<input type="checkbox"/>	

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

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

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

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

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

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