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 _____ Cell Phone: _____

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

Employee ID#: _____ Terminal Degree: _____

Occupation: _____ Division/School/Location: _____

Annual Income: ☐ 0-9,999 ☐ 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? ☐ Outstanding ☐ Above Average ☐ Average ☐ Below Average ☐ Unacceptable
4. How many days has this individual missed during the last 3 months? ☐ None ☐ 1-5 ☐ 5-10 ☐ 11-15 ☐ 16 and over

IV. CONSENT

This section must be read by the identified client and the appropriate signatures are required below.

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. SERVICES RECOMMEDNED

For Campus Assistance Program Use Only	
Services Recommended (CAP will check mark recommended service)	
☐ Fitness for Duty (documentation indicates individual may be impaired)	☐ Threat Assessment (documentation indicates individual may pose a risk)
☐ Drug Testing (Post accident/reasonable suspicion, the drug test must be performed within (8) hours of the incident)	☐ Other:

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

Account	Fund	Department	Program	Class	Project

VI. REASONS FOR REFERRAL
PLEASE PLACE A CHECK IN THE SPACE NEXT TO BEHAVIOR OR SYMPTOMS OBSERVED

	ATTENDANCE
	Excessive absenteeism
	Unusual excuses for absence
	Extended lunch periods
	Early departures
	Excessive lateness
	Frequently leaves work-site

	PERFORMANCE
	Lower quality of work
	Failure to meet deadlines
	Decreased productivity
	Impaired judgment/memory
	Inability to concentrate
	Increased errors
	Erratic patterns

	BEHAVIOR
	Avoids others
	Loss of interest or enthusiasm
	Less communicative
	Sensitive to advise or constructive criticism
	Disregard for safety

	GENERAL APPEARANCE
	Fighting
	Suspicious
	High
	Guarded
	Fearful
	Crying
	Angry
	Irritable
	Anxious
	Mood Swings
	Excited
	Depressed
	Sleepy
	Distracted
	Evasive
	Indifferent
	Polite
	Calm
	Cooperative

	GROOMING
	Bizarre
	Dirty
	Disheveled
	Sloppy
	Messy
	Unkempt
	Neat/acceptable

	SPEECH
	Incoherent
	Slurred
	Slobbering
	Loud
	Rapid
	Slow
	Hesitant
	Soft
	Normal
	Alcohol – like odor on breath

	ABILITY TO STAND
	Unable to stand
	Feet wide apart for balance
	Leaning for balance
	Rigid
	Sagging
	Swaying
	No problem

	ABILITY TO WALK
	Unable to walk
	Falling
	Staggering
	Holding on for stability
	Wobbling
	Weaving
	Swaying
	No problem

	ORIENTATION
	Knows time of day
	Knows his / name
	Knows where he / she is

	ACTIONS
	Threatening
	Profanity
	Punching
	Kicking

	EYES
	Bloodshot
	Watery
	Droopy lids
	Glassy eyed

	FACE
	Flushed
	Pale
	Other

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