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Formal Referral Form

For Referrals to the Employee Assistance Program

Note to the Supervisor: If this is your first time to make a formal referral to the Employee Assistance Program, please refer to the tab **"Formal Referral,"** found on our EAP Website, www.mygroup.com. If you cannot currently access our website, call **704-529-1428** (or 800-633-3353) and ask to speak to the Formal Referral Clinician. Thank you.

Supervisor and Employee Information

Please print

Employee's Name:_____ Referral Date: _____

Employer: _____

Department (if applicable): Employee's Phone: _

Referring Supervisor's Name:_____ Title: _____

Supervisor's Phone (work /cell): _____ Confidential Voice Mail? ☐ Yes ☐ No

Supervisor's E-Mail (optional): _____

Reason for Referral

Please indicate the reason(s) for this referral (check all boxes that apply).

Job Performance Problems

- Lower quality of work
- Decreased productivity
- Increased errors
- Erratic work patterns
- Failure to meet schedules

Attendance

- Excessive tardiness
  - Days late in past month: _____
- Excessive absence
  - Days absent past 3 months: _____
- Other _____

Substance Abuse Problems

Failed random ***drug*** or ***alcohol*** test. (Please circle which one.)
Is the employee in a safety sensitive position? Yes No

- Post-accident failed drug or alcohol test
- Under the influence at work
- CDL holder/DOT violation
- Meets criteria for "reasonable suspicion" (see EAP website for criteria)

Behavioral Concerns

- Avoids supervisor/coworkers
- Less communicative
- Unusually sensitive to feedback
- Unusually critical of others
- Conflict with co-workers
- Disregard for safety
- Frequent mood swings (high or low)
- Loss of interest
- Impaired judgement/memory
- Inability to concentrate

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Violence Issues

Threatened/intimidated others at work (*may require Threat Assessment Meeting)*
Domestic violence
Harassment

Please attach additional comments and/or supporting documentation for any of the above concerns.

Supervisor Performance Goals

1. Have the issues marked on this form been discussed with the employee? ☐ Yes ☐ No
2. What are the consequences if employee performance does not improve?

3. Have the consequences for not improving been discussed with the employee? ☐ Yes ☐ No
4. How will the employee's improvement be measured? (*Please be specific.*)

5. How long will the employee be given to make the desired changes?

Employee Signature

I understand that my supervisor is referring me to the Employee Assistance Program and my signature verifies that I have seen this form. My signature below does not signify my agreement or disagreement with any of the issues raised.

Yes**,** I ***will*** participate in and cooperate with the Employee Assistance Program.
No, I ***will not*** participate in the Employee Assistance Program.

_____ _____

Signature of employee Date

Please forward this form by fax to:
John Trombello, LCMHC, EAP, SAP Formal Referral Clinician or Laura Bryan, PhD, LMFT, SAP, Director McLaughlin Young Group 5925 Carnegie Boulevard, Suite 350, Charlotte, NC 28209
Phone: 704.529.1428 or 1.800.633.3353
Fax: 704.529.5917

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Authorization for Release of Client Records

Client Name: _____ Date of Birth: _____

I request and authorize McLaughlin Young Group (MYG) to:

☐ Release the following information to: ☐ Receive the following information from:

Name of Facility/Person: _____

Address: _____ Phone: _____

Release is for the Purpose of:

- ☐ Continued care by the other provider
- ☐ Attorney
- ☐ Disability
- ☐ Supervisor Referral
- ☐ Personal Review
- ☐ Other (specify): _____

Information to be Disclosed If Requested:

- ☐ Service dates
- ☐ Session constellation
- ☐ Session participants
- ☐ Clinical assessments
- ☐ Summaryoftreatment
- ☐ Other (specify): _____

I understand that the information I am authorizing to be released may include mental health information and any therapy constellation (individual, couple, family, group) in which I have participated.

I further understand that this Authorization is voluntary and I may refuse to sign this Authorization. I further understand that my treatment will not be affected if I do not sign this form (45 C.F.R. 164.508 (c)(2)).

I further understand that I may revoke this Authorization at any time by notifying McLaughlin Young Group (or the releasing facility) in writing by certified mail, return receipt requested to the CEO of MYG, except to the extent that action has been taken in reliance on it. Any such revocation shall not be effective until the next business day following receipt of the revocation notice by MYG. Unless earlier revoked, this Authorization expires automatically 1 year from the day signed or 1 year after the last MYG visit (45 C.F.R. 164.508 (c)(2)).

I further understand that if I refuse to authorize the release of information in a situation where the information is needed by the Employer for legal or other reasons of business necessity, it may limit MYG's ability to continue to provide services in which case MYG may make a referral to another health care provider.

Any person or other entity who receives information pursuant to this authorization should not re-disclose the information to anyone else.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

RELEASE FROM LIABILITY I release and agree to hold harmless MYG (or other releasing facility) and its agents, representatives, and employees from any and all liability associated with the release of confidential client information in accord with this Authorization.

I understand that MYG (or the releasing facility) cannot be responsible for use or re-disclosure of information to third parties (45 C.F.R. 164.508 (c)(2)).

TO THE RECEIVING PARTY OF THIS INFORMATION:
This information has been disclosed to you for the sole purpose(s) stated in this Authorization. Any other use of this information without the express written consent of the client is prohibited. These records may be protected by federal regulation (42 C.F.R. Part 2).

I certify this form was fully explained to me, I have read it or have had it read to me*, and I understand its contents.

_____ _____ _____
Print Client Name/Legally Authorized Person Signature Date

_____ _____ _____
Print Witness/Translator* Name Signature Date

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Dear Employee:

We hope this letter will answer any questions you may have regarding your Employee Assistance Program (EAP). Please read this letter carefully, keep it for future reference, and call us with any additional questions you may have.

You will need to contact your EAP, McLaughlin Young, at 800-633-3353, and they will:

1. Explain your rights to confidentiality.
2. Ask your permission to inform the person referring you as to your participation and compliance. No other information will be released to anyone.
3. Refer you to a clinician in your area who will meet with you and assess your situation.

The clinician in your area will meet with you more than once to thoroughly assess your situation or progress. These sessions will be confidential, and there will be no cost to you for your EAP visits.

The treatment recommendations the clinician makes must be followed. The recommended plan of action may exceed the services covered by the EAP and could mean some out of pocket expense for you. In many cases, your health insurance will pay for treatment.

Again, call us with any questions or concerns you may have. We are here to assist you.

Sincerely,

McLaughlin Young Group Employee Assistance Program