Employee Name: _____

Counselor: Send to VITAL WorkLife no later than 3 days after EAP sessions are concluded. Attach necessary information.

Chemical Assessment Referral Recommendations
Phone 800.383.1908
VITAL WorkLife Fax 320.240.1501

Session Dates: _____ _____ _____ _____ _____ _____

Areas addressed and progress toward each area:

_____

_____

_____

Skill Building Addressed/Assigned:

_____

_____

_____

Recommendations (check all areas that apply and provide details):

☐ Participation in Community Support Groups. Check One: ☐ AA ☐ NA ☐ Other: _____
_____ times per _____ for _____ months
Location: _____

☐ Outpatient chemical dependency treatment (List program information)

☐ In-patient chemical dependency treatment (List program information)

☐ Participation in Alcohol/Drug Education Class (List program information/resources)

☐ Continuation of individual counseling

_____

_____

_____

Recommendations for the Employer:

***(REQUIRED) Recommended re-test and return-to-work date based on self-report of last use or recent testing:** _____

Recommended testing schedule (frequency and time frame, e.g. 3 times per month for the first month, then once a month for 6 months):

_____

_____

☐ Recommendations were shared with the client

Counselor Signature _____ Date _____