Chemical Assessment Referral and Release of Information

Phone 800.383.1908
Fax 320.240.1501

Employee _____ Phone _____
Employer _____
Employer Contact _____ Phone _____
E-mail _____
Other Contact(s) _____ E-mail _____

Positive Test for: _____ Date: _____ Level(s) if known: _____

Note: Substance Abuse Professional (SAP) evaluations are not covered in the EAP.

Please describe, as specifically as possible, why the employee is being referred. *Attach additional information that would be helpful for the counselor to address your concerns, e.g. behavior issues related to chemical use, written warnings, previous corrective action, etc.*

_____

_____

_____

Are there any specific requests or information sought by the employer as part of the assessment, e.g. required number of sessions with the counselor, specific testing schedule, negative UA in order to return to work, etc.?

_____

_____

_____

_____

The employee is expected to contact VITAL WorkLife by _____ (date) to initiate setting up an appointment.
By signing this form, the employee authorizes VITAL WorkLife and/or contracted consultant to release and/or exchange pertinent information with their employer. If the employee fails to follow through with the appointment, VITAL WorkLife will notify the employer.
Information to be disclosed: ***Please strike out and initial any area you revoke to be disclosed.***

- Attendance at EAP counseling session(s)
- Engagement, investment and cooperation of employee throughout the EAP process
- Skill building being addressed and progress toward behavior change
- Recommendations of VITAL WorkLife Counselor and/or contracted consultant

I understand that I may refuse to sign this consent, but that refusal may have consequences which have been explained to me by my employer. I understand that I may revoke this consent at any time and that this consent expires upon fulfillment of the above indicated purpose(s) or one year after signature date, whichever occurs first. I understand that revoking my consent may have consequences also.

Employee Signature _____ Date _____

Employer Representative _____ Date _____

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 _____