COMMUNITY HEALTH NETWORK EAP
Manager Referral Form

This form is to be completed by the manager referring an employee to EAP. Please fax back to EAP as soon as possible: 317-621-7353 (fax)

Name of Employee Being Referred:_____ Title:_____

Date of Employment: Month_____ Year_____

Length of Time in Current Position: Years _____ Months _____

Is this employee's position regulated by DOT or MICCS polices? □ Yes □ No

Name of Supervisor Making Referral:_____ Title:_____

Date & time of manager's call for referral: _____

Time Frame for Employee to Call EAP: _____

Type of referral: □ Positive Alcohol/Drug Screen □ Work Performance Issues

Frequency of reports to the manager: □ Weekly □ Monthly □ None requested

Preferred form of communication: □ phone □ email

Please check each job performance issue that caused you to refer this employee to EAP for assistance and provide specific comments about the checked issue(s).

- □ Absenteeism/Tardiness
- □ Work quality/Quantity
- □ Co-worker/Peer Relations
- □ Supervisor/Manager Relations
- □ Customer/Vendor Relations
- □ Other Work Issue

_____

_____

By signing below I give my permission to have this information discussed by the EAP provider with the employee. This consent will be valid for as long as needed but is not to exceed 60 days.

Manager's Signature:_____

Printed Name:_____

Date: _____

Telephone:_____ Fax:_____E-Mail:_____

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317-621-7742 or 1-800-543-4158