

CONCERN: EAP

1503 Grant Road, Suite 120, Mountain View, CA 94040



Please note: A first step in making a successful referral is to call CONCERN at 1-800-344-4222. We'll take you through the process of referring an employee. Otherwise, a CONCERN Clinical Manager will be in contact with you once your referral is received.

SUPERVISOR REFERRAL FORM

This form is to be used as a guide to help the *CONCERN: EAP* counselor understand the nature and extent of the employee's job performance issues and the improvement you would like to see. Please fill out the form as completely as possible and fax it to CONCERN at 650-962-5737. Feel free to add additional pertinent information on separate sheets. *A copy of the form should be given to the employee after your discussion of the referral.*

Employee Name: _____ Employee's Job Title: _____
Company Name: _____ Today's Date: _____
Referred By: _____ Title: _____ Phone: _____

REASON(S) FOR REFERRAL

Performance difficulties: *(Please check all that apply)*

- | | |
|---|--|
| <input type="checkbox"/> Difficulty working with others | <input type="checkbox"/> Reduced overall job efficiency |
| <input type="checkbox"/> Poor quality or quantity of work | <input type="checkbox"/> Communication problems |
| <input type="checkbox"/> Erratic work patterns <i>(e.g. periods of high and low productivity, etc.)</i> | <input type="checkbox"/> Poor concentration <i>(e.g., frequent errors, etc.)</i> |
| <input type="checkbox"/> Excessive absenteeism, tardiness, etc | <input type="checkbox"/> Safety or other policy violations |
| # of occurrences _____ # of days _____ Is there a pattern? Yes No | <input type="checkbox"/> Other _____ |

Please describe *specific* changes you would like your employee to make to improve his or her performance:

Have the above observations been discussed with the employee on previous occasions? Yes No

If yes, list date of first discussion: _____ Date of second discussion: _____

EMPLOYEE SIGNATURE AND RELEASE OF INFORMATION

By signing below, I, _____ *(print employee's name)*, hereby authorize CONCERN: EAP and the supervisor or HR staff listed above to exchange pertinent information regarding my contacting or failing to contact CONCERN: EAP*.

*(*Please Note: No other information can be released without a signed Release of Protected Health Information.)*

My signature also serves to acknowledge that I understand that information regarding my work performance related to this Supervisor Referral has been shared with CONCERN: EAP, and that the relevant policies and procedures affecting me have been explained to me.

Employee Signature Date

As a supervisor or HR representative, I have explained the relevant policies and procedures described in this form. The employee has indicated his/her understanding of these issues.

Supervisor/HR Signature Date

Employee given copy of this form? Yes No

Please fax (*preferably*) completed form as soon as possible to 650-962-5737, Att: Clinical Manager or mail to Clinical Manager, CONCERN: EAP 1503 Grant Road, Suite 120 Mountain View, CA 94040