



Supervisor Referral Forms

This packet of forms allows BJC EAP to release specific information regarding an employee's consultation to a particular party within his or her company.



Fax Cover Sheet

CONFIDENTIAL

Date: _____

To: BJC Employee Assistance Program (EAP)

Fax:

- Steinberg Building 314-454-5039
- 605 Old Ballas 314-989-0712
- Christian Hospital 314-653-4341
- Kirkwood 314-729-4002

From: _____

of pages: _____ (including cover sheet)

Comments: _____

Call 314.729.4030 or toll-free 888.505.6444 if there are any problems regarding this fax transmittal
343 South Kirkwood, St. Louis, Missouri 63122 USA
Fax 314-729-4002

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**BJC EMPLOYEE ASSISTANCE PROGRAM
MANAGEMENT REFERRAL INFORMATION FORM**

CALL CENTER INFORMATION

Date and time of initial contact ___/___/___ :___ am pm EAP Consultant: _____
 Date and time of EAP appointment ___/___/___ :___ am pm _____

MANAGEMENT INFORMATION

When referring an individual to the eap, please identify and evaluate the areas of work performance breakdown using the criteria below. Be specific and add any additional information you feel would be useful. Please include any other previous corrective action.

This form must be received by the EAP prior to the employee’s scheduled appointment

Employee Name Last First Mi Employee SS# Department Phone #

Name of Supervisor/Management Representative Making Referral Phone #

Work Performance Problem		Severity Of Problem				
		Minor				Severe
Absenteeism (Full Day)	<input type="checkbox"/>	1	2	3	4	5
Partial Day Absences	<input type="checkbox"/>	1	2	3	4	5
Tardiness	<input type="checkbox"/>	1	2	3	4	5
“Unscheduled” Vacation Days	<input type="checkbox"/>	1	2	3	4	5
Decline In Quality Of Work	<input type="checkbox"/>	1	2	3	4	5
Decline In Quantity Of Work	<input type="checkbox"/>	1	2	3	4	5
Change In Personality	<input type="checkbox"/>	1	2	3	4	5
Disruptive Behavior	<input type="checkbox"/>	1	2	3	4	5
Change In Work Habits	<input type="checkbox"/>	1	2	3	4	5
Safety Record	<input type="checkbox"/>	1	2	3	4	5
Excessive Time Away From Area	<input type="checkbox"/>	1	2	3	4	5
Other	<input type="checkbox"/>	1	2	3	4	5
Other	<input type="checkbox"/>	1	2	3	4	5
Other	<input type="checkbox"/>	1	2	3	4	5

MANAGEMENT/EMPLOYEE DISCUSSIONS/DISCIPLINARY ACTION

Date:_____ Reason:_____ Result:_____

Date:_____ Reason:_____ Result:_____

Date:_____ Reason:_____ Result:_____



PLAN OF ACTION FOR PERFORMANCE IMPROVEMENT

(TO BE FILLED OUT BY SUPERVISOR AND EMPLOYEE)

Work performance problem(s): _____

Goals to improve job performance:

1. _____

2. _____

3. _____

4. _____

5. _____

Specific actions employee can take to improve work performance:

1. _____

2. _____

3. _____

4. _____

5. _____

Supervisor's signature: _____ Date: _____

Employee's signature: _____ Date: _____

TO BE COMPLETED BY EAP CONSULTANT

Contact with supervisor before Appt. Date: _____ time: _____

Date paperwork was received: _____

Notes or summary of pre-appointment contact with supervisor: _____

Follow up employee appts: _____

Follow up supervisor contacts: _____



Management Referral Information Form Instructions

1. **Management Referral Information Form** — used when a supervisor refers an employee to EAP for work performance problems
2. **Call Center Information** — to be completed by Call Center staff — the date and time of initial contact and date and time of EAP appointment and name of EAP consultant are completed by the Call Center — the rest of the form is to be completed by the supervisor/ manager who is making the referral
3. **Management Information** — manager/supervisor is to complete this section providing employee name, social security, department, phone number and include his/her name and telephone number
4. **Work Performance Problem** — manager/supervisor then indicates which performance problem(s) are applicable and rates the severity
5. **Management/Employee Discussions/Disciplinary Action** — if the manager/supervisor has discussed the work performance problem with the employee in the past, and/or if disciplinary action has been taken: the dates, reasons and results (corrective action) of those occurrences should be recorded here; for example:
Date: Jan. 1, 2012 **Reason:** excessive absenteeism **Result:** 1st Written Warning
6. **Plan of Action for Performance Improvement** — to be completed by the manager/supervisor and employee together
 - **Work Performance Problem(s)** — a description of the work performance problem as understood by both, the employee and the supervisor: this description might be worded differently than the work performance problems listed on the front of the form
 - **Goals to Improve Work Performance** — list all possible goals that will represent an improvement in job performance
 - **Specific Actions Employee Can Take to Improve Work Performance** — list ideas and strategies developed by both the employee and supervisor that will facilitate the improvement of work performance
 - **Supervisor's Signature and the Date and Employee's Signature and the Date**
7. **To Be Completed by EAP Consultant** — this section is completed by the EAP Consultant and records the initial contact with manager/supervisor, the date the paperwork was received and subsequent follow up contacts with employee and manager/supervisor
8. **Information Release Authorization** — employee completes this form and the manager/supervisor signs and dates as the witness



**BJC Employee Assistance Program
Information Release Authorization**

In accordance with 42 C.F.R. Part 2, I John Doe 000-00-0000

[insert employee name and social security number], hereby give permission to the agents or employees of BJC Employee Assistance Program to:

DISCLOSE the following information to OBTAIN the following information from

Your Company Name
(Name of Agency, Attorney, Employer, etc.)

Human Resources and Supervisor (names)

1234 Any Street, Anytown, Anystate 123456 USA
(Address: City, State, ZIP Code) (Phone) (Fax)

INFORMATION TO BE RELEASED:

- All information in my record; or Other [Specify Information]:
 - attendance at EAP sessions
 - compliance with plan of treatment
 - work considerations

The purpose for the release of the information is: Progress and Follow-up

I understand that I may revoke this Authorization at any time, except to the extent that the Releasing Party has already taken action in reliance on said Authorization. Such revocation also has no effect until the written revocation is received by the Releasing Party. If not previously revoked, this consent will terminate within one (1) year from the date noted below.

I have read and understand this form. All of my questions have been answered. I sign my name freely, voluntarily and without coercion.

Signature of Client John Doe

Signature of Parent/Guardian John Doe, Sr. Date 1-1-2012

Social Security Number 000-00-0000 Date of Birth 1-1-1982

Witness manager/supervisor name Date 1-1-2012

This form must be signed by a competent adult. If the person whose records to be released is under the age of 18, or incompetent, then this Authorization must be signed by a parent or guardian or other qualified personal representative.

NOTICE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from records, the confidentiality of which are protected by federal and/or state laws and regulations. Accordingly, you are prohibited from making any further disclosure of this information without the specific prior written consent of the person to whom the information pertains, or as otherwise permitted by such laws and regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.



**BJC Employee Assistance Program
Information Release Authorization**

In accordance with 42 C.F.R. Part 2, I _____

[insert employee name and social security number], hereby give permission to the agents or employees of BJC Employee Assistance Program to:

- DISCLOSE the following information to OBTAIN the following information from

(Name of Agency, Attorney, Employer, etc.)

(Address: City, State, ZIP Code) (Phone) (Fax)

INFORMATION TO BE RELEASED:

- All information in my record; or Other [Specify Information]: attendance at EAP sessions compliance with plan of treatment work considerations

The purpose for the release of the information is: Progress and Follow-up

I understand that I may revoke this Authorization at any time, except to the extent that the Releasing Party has already taken action in reliance on said Authorization. Such revocation also has no effect until the written revocation is received by the Releasing Party. If not previously revoked, this consent will terminate within one (1) year from the date noted below.

I have read and understand this form. All of my questions have been answered. I sign my name freely, voluntarily and without coercion.

Signature of Client _____

Signature of Parent/Guardian _____ Date _____

Social Security Number _____ Date of Birth _____

Witness _____ Date _____

This form must be signed by a competent adult. If the person whose records to be released is under the age of 18, or incompetent, then this Authorization must be signed by a parent or guardian or other qualified personal representative.

NOTICE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from records, the confidentiality of which are protected by federal and/or state laws and regulations. Accordingly, you are prohibited from making any further disclosure of this information without the specific prior written consent of the person to whom the information pertains, or as otherwise permitted by such laws and regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.



Information Release Authorization Form Instructions

1. **Two-way release** — to be used for providing (Disclose) information to a referring agent and receiving (Obtain) information from a provider
2. **First blank** — fill in the name of employee
3. **Disclose** — check and provide name, phone and fax number of the manager/supervisor making the referral
4. **Obtain** — check and provide name, address, phone and fax number of the employee
5. **Information to be released** — check other and check all three categories
6. **Signature of client** — employee needs to sign, date, provide social security number and date of birth
7. **Signature of parent/guardian** — not applicable for management referrals
8. **Witness** — manager/supervisor to sign and date at the witness signature line
9. **Legal document** — original is kept in case record; copy provided at employee request