Work Force

**Employee Assistance Program & Training**
470 Forest Avenue Ste 305
Portland, ME 04101

**Office** 800.769.9819
**Fax** 207.773.5337

# Case Report Form



**Completed Case Reports must be *mailed or faxed* with Billing Form. Billing Form should be submitted monthly and *must be received within 45 days of service delivery*. Billing Forms submitted after 45 days from service delivery and/or with incomplete Case Reports will not be paid.**

Client Name: _____ Primary Phone #: _____

Client Company: _____ Alt. Phone: _____

Specific Work Location: _____ State: _____ Email: _____

Mailing Address: _____ Gender: ☐ Male ☐ Female

City: _____ Date of Birth: _____ Age: _____

State: _____ Zip: _____

Agency and/or Counselor Providing Service _____

Length of time between first contact and first appointment offered
☐ 24 Hours or Less ☐ 24 to 48 Hours
☐ 48 to 72 Hours ☐ more than 3 days

Please explain if more than 3 business days _____

| | | | |
|---|---|---|---|
| **Relation to Employee:** | ☐ Child<br>☐ Partner/Spouse | ☐ Employee<br>☐ Other Household member | ☐ Other _____ |
| **Length of Employment:** | ☐ Less than 1 year<br>☐ 10 to 15 Years<br>☐ Household member N/A | ☐ 1 to 5 Years<br>☐ 15 to 20 Years | ☐ 5 to 10 Years<br>☐ More than 20 Years |
| **Referral Source:** | ☐ Brochure/Newsletter<br>☐ Human Resources<br>☐ Supervisory Mandated | ☐ Friend/Co-worker<br>☐ Self<br>☐ DOT/Drug Testing Violation | ☐ Family<br>☐ Supervisory Encouraged<br>☐ Other |
| **Presenting Problem:** | ☐ Addictive Behavior (not s/a)<br>☐ Addictive Behavior (not s/a) - Family<br>☐ Couples/Marital<br>☐ Domestic Violence<br>☐ Family – Child Related<br>☐ Family – Elder Care<br>☐ Family - Other<br>☐ Financial<br>☐ Legal | ☐ Mandatory Referral<br>☐ Personal - Anger<br>☐ Personal - Anxiety<br>☐ Personal - Depression<br>☐ Personal – Eating Disorder<br>☐ Personal – Grief /Loss<br>☐ Personal - Interpersonal<br>☐ Personal - Medical<br>☐ Personal - Stress<br>☐ Personal - Other | ☐ Positive non-DOT Test<br>☐ Substance Abuse<br>☐ Substance Abuse - Family<br>☐ Workplace - Career<br>☐ Workplace - Interpersonal<br>☐ Workplace - Stress<br>☐ Workplace - Transition<br>☐ Workplace - Violence<br>☐ Workplace - Other<br>☐ Other |

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# EAP Client Case Report

*To be mailed or faxed, do not email*

Client Name _____ Type of Session ☐ Individual ☐ Couple ☐ Family

Date of First EAP Session _____

Brief clinical observations and interventions _____

Is further EAP assessment indicated? ☐ YES ☐ NO Please Explain _____

Can problem resolution occur within EAP benefit? ☐ YES ☐ NO **(If NO, please make appropriate referral using client's insurance network and/or other resources available. Close Case Report and fax/mail with Billing Form.**

Date of EAP Session _____ Type of Session ☐ Individual ☐ Couple ☐ Family

Clinical rationale for additional session within EAP

Brief clinical observations and interventions

Can problem resolution occur within EAP benefit? ☐ YES ☐ NO **(If NO, please make appropriate referral using client's insurance network and/or other resources available. Close Case Report and fax/mail with Billing Form.**

Date of EAP Session _____ Type of Session ☐ Individual ☐ Couple ☐ Family

Clinical rationale for additional session within EAP

Brief clinical observations and interventions

**If EAP client's benefit allows additional sessions for problem resolution you must complete brief clinical observations and interventions for each session. You may use an additional Case Report for those purposes.**

**Closing Recommendation:**

- ☐ Additional EAP Counseling
- ☐ Inpatient Program
- ☐ Outpatient Counseling
- ☐ Psycho Educational Material / Self Help
- ☐ Referral to Spiritual Resource
- ☐ EAP Counseling only
- ☐ Intensive Outpatient / Partial Day
- ☐ Medical Assessment
- ☐ Referral to Legal / Financial Resource
- ☐ Referral to Community Resource

If referral was made, referred to: _____

**Any self-referral for ongoing counseling must be pre-approved by an EAP counselor by calling 1-800-769-9819.**

Signature of Counselor Providing Service: _____ Date _____