SUPERVISOR REFERRAL FORM

For Mandatory Referrals To The

EMPLOYEE ASSISTANCE PROGRAM

Note to the Supervisor: If this is your first time to make a mandatory referral to the Employee Assistance Program, please call **806-743-1327** (or 800-327-0328) and ask to speak to the EAP Director. Thank you.

SUPERVISOR AND EMPLOYEE INFORMATION

Please print

Employee's Name: _____ Referral Date: _____

Employer: _____

Department (if applicable): _____ Employee's Phone: _____

Referring Supervisor's Name: _____ Title: _____

Supervisor's Phone (work /cell): _____ Confidential Voice Mail? Yes No

Supervisor's E-Mail (optional): _____

REASON FOR REFERRAL

Please indicate the reason(s) for this referral (*check all boxes that apply*).

JOB PERFORMANCE PROBLEMS

Lower quality of work
Decreased productivity
Increased errors
Erratic work patterns
Failure to meet schedules

Attendance
- Excessive tardiness
  Days late in past month: ____
- Excessive absence
  Days absent past 3 months: _____
- Other _____

SUBSTANCE ABUSE PROBLEMS

Failed random ***drug*** or ***alcohol*** test. (*Please circle which one.*)
Is the employee in a safety sensitive position? Yes No
Post-accident failed drug or alcohol test
Under the influence at work
Meets criteria for "reasonable suspicion" (*see EAP website for criteria*)

BEHAVIORAL CONCERNS

Avoids supervisor/coworkers
Less communicative
Unusually sensitive to feedback
Unusually critical of others
Conflict with co-workers
Disregard for safety
Frequent mood swings (high or low)
Loss of interest
Impaired judgment/memory
Inability to concentrate

- continued -

VIOLENCE ISSUES

Threatened/intimidated others at work (*may require Threat Assessment Meeting*)
Domestic violence
Harassment

Please attach additional comments and/or supporting documentation for any of the above concerns.

SUPERVISOR PERFORMANCE GOALS

1. Have the issues marked on this form been discussed with the employee? Yes No
2. What are the consequences if employee performance does not improve?
3. Have the consequences for not improving been discussed with the employee? Yes No
4. How will the employee's improvement be measured? *(Please be specific.)*
5. How long will the employee be given to make the desired changes?

EMPLOYEE SIGNATURE

I understand that my supervisor is referring me to the Employee Assistance Program and my signature verifies that I have seen this form. My signature below does not signify my agreement or disagreement with any of the issues raised.

Yes, I ***will*** participate in and cooperate with the Employee Assistance Program.
No, I ***will not*** participate in the Employee Assistance Program.

_____ _____
Signature of employee Date

Please forward this form by mail or fax to:
Alan Korinek, Ph.D, Director
Texas Tech University Health Sciences Center
Department of Psychiatry – STOP 8103
3601 4th Street
Lubbock, TX 79430-8103
Phone: 806.743.1327 or 1.800.327.0328
Fax: 806.743.1323
