RETURN WITHIN
72 HOURS
OF FIRST
SESSION

EMPLOYEE ASSISTANCE PROGRAM

ASSESSMENT / TREATMENT PLAN

CLIENT NAME: ________________________________ **COMPANY:** ________________________________

EAP COUNSELOR'S NAME: (Please print) ____________________________ **Your Agency:** ______________

Agency City: __________________ **Phone No:** _______________

INITIAL SESSION INFORMATION

DATE 1ST SESSION ___________ **Number of people seen in session?** _____

Recent suicidal or homicidal intent or plan? ☐ **Yes** ☐ **No (If yes, please contact us.)**
Recent physical or sexual abuse? ☐ **Yes** ☐ **No (If yes, please contact us.)**

Primary Assessed Issue: ____________________________ **Secondary Assessed Issue:** ___________________

Therapy Type: ☐ **Individual** ☐ **Couple** ☐ **Family**

EAP COUNSELING SESSIONS REQUESTED

Please check one of the following:
☐ **Additional EAP sessions are requested** **Number of Sessions:** _________

☐ **Client refused recommendations no sessions requested**

☐ **Only one assessment session needed** ☐ **Client referred to long term treatment**

TREATMENT FOCUS

Problem	Goals/Objectives	Intervention
1		
2		
3		

REFERRING BEYOND EAP

A referral beyond EAP is needed: ☐ **Yes** ☐ **No**
(If so, please check the following)
☐ **AODA Outpatient** ☐ **AODA Inpatient** ☐ **Outpatient Mental Health** ☐ **Inpatient Mental Health**
Other (please specify): ____
Non-treatment Services: ☐ **Legal** ☐ **Financial** ☐ **Medical** ☐ **Occupational** ☐ **Other:** __________________
Agency Referred To:
Provider: ____________________________ **Provider:** ____________________________
Address: ____________________________ **Address:** ____________________________
Phone: ____________________________ **Phone:** ____________________________
Notice: If client is to continue to receive services (beyond the scope of EAP) at the Affiliate which will be charged to insurance, the Freedom of Choice information on the Closing Form must be signed and sent to ThedaCare EAP.

EAP Counselors Signature: ____ **Date:** ________________

**** PLEASE FAX THIS FORM TO THEDACARE EAP WITHIN 72 HOURS OF SEEING THE REFERRED CLIENT(S). ****

Fax Number: 920-749-2399 **Phone numbers: 920-749-2390 * 1-800-236-3666**