Appendix 3. EAP Supervisory Referral Form
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STATE OF MARYLAND - EAP SUPERVISORY REFERRAL FORM

The purpose of this form is to provide information to the Employee Assistance Program (EAP) regarding an employee who may have a personal problem that may negatively impact (or has negatively impacted) their job performance. Additionally, please note that the EAP contractor will inform the State's EAP Coordinator of each instance where an employee attends or fails to attend a scheduled EAP counseling session. **THIS FORM MUST BE SUBMITTED TO THE EAP COORDINATOR. IN THE SPACE PROVIDED PLEASE WRITE BRIEF A SYNOPSIS EXPLAINING THE BASIS FOR REFERRAL.**

Please print legibly in ink or type. REFERRAL DATE: _____

COMPLETE EMPLOYEE INFORMATION BELOW:

EMPLOYEE'S NAME: _____ W#: _____

GENDER: □ FEMALE □ MALE □ NON-BINARY/THIRD GENDER □ PREFER TO SELF-DESCRIBE □ PREFER NOT TO SAY

HOME ADDRESS: _____
(Address, City, State, and Zip Code)

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

WORK EMAIL: _____ PERSONAL EMAIL: _____

CLASSIFICATION: _____ GRADE: _____

START DATE: _____ DATE OF BIRTH: _____ MARITAL STATUS: _____

DEPARTMENT/AGENCY NAME: _____
(Do not use acronyms)

WORK ADDRESS: _____
(Address, City, State and Zip Code)

WORK HOURS/SHIFT: _____ DAYS OFF: _____
(Use 12 hour clock - DO NOT use military time)

COMPLETE AGENCY CONTACT INFORMATION BELOW:

SELECT REFERRAL TYPE: ☐ **SUPERVISORY** ☐ **MANAGEMENT**

REFERRED BY: _____ PHONE: _____

TITLE: _____ FAX: _____

AGENCY EAP REPRESENTATIVE: _____ PHONE: _____

TITLE: _____ FAX: _____

AGENCY EAP REPRESENTATIVE EMAIL: _____

MAILING ADDRESS: _____

_____ _____
Agency EAP Representative (Print Name) Agency EAP Representative (Signature)

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REASON FOR REFERRAL

FORM COMPLETION STEPS

#1: Select referral type.
#2: Select each applicable subcategory as it relates to the requested referral type.
#3: Attach all supporting documentation and/or provide a synopsis that supports referral type and corresponding subcategories.

I. ☐ **SUBSTANCE ABUSE REFERRAL**

***VIOLATION OF GOVERNOR'S EXECUTIVE ORDER REGARDING SUBSTANCE ABUSE*:** **YES/NO (Circle One)**

_____ Failed random drug test _____ Alcohol related conviction _____Other

II. ☐ **MENTAL HEALTH REFERRAL**

ATTENDANCE *(Please place numbers where numbers are requested)*

_____ # of days absent in past 12 month

_____ # of times late in past six (6) months

_____ Other

_____ # of extended lunches past six (6) months

_____ Pattern (e.g., Mondays, Fridays, after paydays, before and after holidays). Please describe: _____

JOB PERFORMANCE (Please provide supporting documentation for any items checked below):

_____ Lower quality of work

_____ Decreased productivity

_____ Increased errors

_____ Impaired judgment/memory

_____ Erratic work patterns

_____ Failure to meet schedules

_____ Inability to concentrate

_____ Other

BEHAVIOR DEMONSTRATED WITH RESPECT TO JOB PERFORMANCE

_____ Avoids supervisors/coworkers

_____ Less communicative

_____ Disregard for safety

_____ Loss of interest

_____ Unusually sensitive to advice/constructive criticism

_____ Unusually critical of supervisor/coworkers/employer

_____ Frequent mood swings

_____ Other

DOMESTIC VIOLENCE

_____

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SYNOPSIS_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have the above issues been discussed with employee? Yes/No (Circle One)

Has employee been referred to State Medical Director? Yes/No (Circle One)

IF EMPLOYEE INTENDS TO PARTICIPATE, THIS REFERRAL CANNOT BE PROCESSED WITHOUT "YES" INDICATED BELOW AND THE EMPLOYEE'S SIGNATURE

I understand that my employer is referring me to the State Employee Assistance Program. I also understand that my signature below does not reflect my agreement or disagreement with any of the issues raised. My signature verifies that I have seen this referral and all documentation contained therein and that I consent to and authorize the EAP Contractor to release my attendance, or lack thereof, to the State. I understand this consent becomes effective on the date I sign it, and will continue in effect for the duration of the contract term between the State Employee Assistance Program and EAP Contractor. I agree to release the above named individual(s) or organization(s) and the EAP, the EAP counselor, and his/her designee from liability that may result from furnishing this information as authorized in this disclosure.

____ **YES**, I will participate in the Employee Assistance Program ___**NO,** I will not participate in the Employee Assistance Program

Name of Health Insurance Carrier _____

_____ _____

Employee Signature Date

Your agency EAP Representative will securely forward this form and all supporting documentation to:

EAP@maryland.gov or 410-333-7603 (fax)

If you have questions, please contact the Employee Assistance Program at 410-767-5846 or 410-767-1314.

FAILURE TO LEGIBLY AND FULLY COMPLETE THIS FORM WILL RESULT IN APPOINTMENT DELAY.

STATE EAP COORDINATOR ONLY

URGENT: Yes/No (Circle One) **DATE:** _____

COMMENTS: _____

PRINT NAME: _____ **SIGNATURE:** _____