



**Family Service EAP
Referral Form**

Company Name: _____

Date of Referral: _____

Type of Referral (Please check):

- Formal – (Performance/conduct related
- Mandatory – (Drug/alcohol related)

Employee Name: _____ **Title:** _____

Employee Phone: _____

Company Representative: _____ **Title:** _____

Phone: _____ **Fax:** _____

Reason for Referral (please specify duration of existing problem and steps taken):

Company Representative: _____

Signature Date

EAP WILL FAX FORM BACK TO THE COMPANY AFTER 1ST VISIT IF THERE IS A
SIGNED RELEASE OF INFORMATION.

FOR STAFF USE ONLY

Family Service Staff: _____ **Date of 1st visit:** _____