**Employee Assistance Program (EAP) Referral Form**

**Section 1: Employee Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Employee Name |  | | |
| Employee ID |  | Department / Division |  |
| Job Title |  | Contact Number |  |
| Email Address |  | Supervisor / Manager |  |
| Date of Referral |  |  |  |

**Section 2: Type of Referral**

☐ **Self-Referral** – Employee voluntarily seeks EAP support.  
☐ **Supervisory Referral** – Manager recommends EAP due to performance or behavioral issues.  
☐ **Mandatory Referral** – HR requires EAP participation as part of performance or conduct management.

**Section 3: Reason for Referral**

(Select all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| **Area of Concern** | **Tick (✔)** | **Area of Concern** | **Tick (✔)** |
| Work-related stress | ☐ | Job performance decline | ☐ |
| Attendance or punctuality issues | ☐ | Substance or alcohol concerns | ☐ |
| Conflict with coworkers or supervisors | ☐ | Emotional distress or anxiety | ☐ |
| Family or relationship difficulties | ☐ | Financial difficulties | ☐ |
| Other (please specify): | ☐ |  |  |

**Section 4: Summary of Concerns / Observations**

*(Briefly describe the situation, observed behavior, or reason for referral)*

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**Section 5: Actions Taken Prior to Referral**

|  |  |  |
| --- | --- | --- |
| **Action / Support Attempted** | **Date** | **Outcome** |
|  |  |  |
|  |  |  |

**Section 6: EAP Counselor / Service Provider Information**

|  |  |
| --- | --- |
| Counselor Name |  |
| Organization / Clinic |  |
| Contact Information |  |
| Appointment Date |  |
| Follow-up Date (if applicable) |  |

**Section 7: Confidentiality and Consent**

*All information provided is confidential and will only be shared with authorized personnel for EAP-related purposes.*

☐ I consent to participate in the Employee Assistance Program.  
☐ I understand that this referral does not affect my employment status or performance review.

**Employee Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Manager / HR Representative Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 8: For EAP Counselor Use Only**

|  |  |
| --- | --- |
| Initial Assessment Summary |  |
| Recommended Support / Intervention |  |
| Number of Sessions Provided |  |
| Counselor’s Signature |  |
| Date |  |