ALLONE HEALTH

After completing this form, please email to
aoheastcoastalsup@allonehealth.com

FITNESS FOR DUTY EVALUATION
REFERRAL FORM

PLEASE PRINT OR TYPE

Employee Information

Last Name:	**First Name:**		**Middle Initial:**
Phone #:	**Email:**		
Street Address:	**City:**	**State:**	**Zip Code:**
Company:	**Work Location:**	**Position:**	**Length of Employment:**

Referring HR/Supervisor Information

Last Name:	**First Name:**	
Position:	**Phone #:** ☐ Mobile ☐ Office	**Email:**

Detailed Reason for the Referral

Please use the space below or attach documentation when submitting the referral.

Is there a concern related to the employee's potential for violence? If yes, please provide explanation.

Potential for Violence: ☐ Yes ☐ No	**Explanation of Potential for Violence:**

Has the employee communicated a threat? If yes, please provide explanation.

Communicated Threat: ☐ Yes ☐ No	**Explanation of Communicated Threat:**

Has the employee been suspended or are they currently on a leave of absence? If yes, please complete the following.

Suspended/Leave of Absence: ☐ Yes ☐ No	**Type of Leave:**	**Effective Date:** / /
Date HR/Manager Discussed the Above Referral Reasons with Employee: / /	**Date by Which Employee Is to Contact AllOne Health to Begin the Process:** / /	**Phone # Employee Is to Contact:**

PLEASE INSTRUCT THE EMPLOYEE WHEN THEY CALL TO STATE THEY ARE BEING FORMALLY REFERRED BY THEIR EMPLOYER.

Referring HR/Supervisor Signature:	**Date:** / /
Employee Signature:	**Date:** / /

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RELEASE OF INFORMATION AUTHORIZATION

PLEASE PRINT OR TYPE

I understand that my employer has formally referred me to the Employee Assistance Program (EAP). I agree to follow the recommendations of the assigned EAP provider as requested by my employer. Continued employment is based on my employer's policies, not those of AllOne Health or those of its network providers.

Release of Information Authorization will end one year from the date this form was signed. Approval may be withdrawn at any time by giving written notice to the EAP listed below. I understand that if approval is withdrawn, any prior approval already given cannot be withdrawn.

I acknowledge that my signature below indicates my acceptance of these terms.

By signing this form, I agree for the below information to be released

- Contact made with EAP
- Scheduling of EAP sessions
- Attendance of EAP sessions
- Following EAP recommendations

Person, company, or group allowed to release/receive the information

- Employee Assistance Program Professionals
- EAP Providers
- Employer Representative(s) listed below

Employer Representative Name:
Additional Contacts to Receive Case Updates (Include Name and Email):

Employee Signature:	**Date:** / /