ALL ONE HEALTH

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

FORMAL MANAGEMENT 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:

Referral Information

Reason for Referral (Please Check All That Apply):

☐ Policy Violation* ☐ Performance ☐ Behavioral/Conduct ☐ Attendance/Presenteeism ☐ Other

**i.e. Substance Abuse Policy, Workplace Violence Policy, etc.*

Please Provide Detail for Any Boxes Checked (Specific and Objective Observations):

Desired Outcome and Goals:

If this is a recurring problem, please complete the following and attach any additional documentation.

Steps Taken Prior to This Referral (Verbal Conversation, Suspension, Coaching, PIP, LCA):

Referral Information (Continued)

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

Suspended/Leave of Absence:	Type of Leave:	Effective Date:
☐ Yes ☐ No		/ /

Can the employee return to work while completing EAP recommendations?	Can the employee attend EAP sessions during work hours?
☐ Yes ☐ No	☐ Yes ☐ No

If a drug/alcohol screening test was performed, please complete the following.

Type of Test:		
☐ Random	☐ Post-Accident	☐ Reasonable Suspicion

Test Date:	Tested Positive for:	Quantitative Levels:
/ /		

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 Approval may be withdrawn at any time by giving written notice to the EAP listed below.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:** / /