Work Force

Employee Assistance Program & Training
470 Forest Avenue Ste 305
Portland, ME 04101

Office 800.769.9819
Fax 207.773.5337

Case Report Form

Completed Case Reports must be *mailed or faxed* with Billing Form. Billing Form should be submitted monthly and *must be received within 45 days of service delivery*. Billing Forms submitted after 45 days from service delivery and/or with incomplete Case Reports will not be paid.

Client Name: _____ Primary Phone #: _____

Client Company: _____ Alt. Phone: _____

Specific Work Location: _____ State: _____ Email: _____

Mailing Address: _____ Gender: ☐ Male ☐ Female

City: _____ Date of Birth: _____ Age: _____

State: _____ Zip: _____

Agency and/or Counselor Providing Service _____

Length of time between first contact and first appointment offered
☐ 24 Hours or Less ☐ 24 to 48 Hours
☐ 48 to 72 Hours ☐ more than 3 days

Please explain if more than 3 business days _____

Relation to Employee:	☐ Child ☐ Partner/Spouse	☐ Employee ☐ Other Household member	☐ Other _____
Length of Employment:	☐ Less than 1 year ☐ 10 to 15 Years ☐ Household member N/A	☐ 1 to 5 Years ☐ 15 to 20 Years	☐ 5 to 10 Years ☐ More than 20 Years
Referral Source:	☐ Brochure/Newsletter ☐ Human Resources ☐ Supervisory Mandated	☐ Friend/Co-worker ☐ Self ☐ DOT/Drug Testing Violation	☐ Family ☐ Supervisory Encouraged ☐ Other
Presenting Problem:	☐ Addictive Behavior (not s/a) ☐ Addictive Behavior (not s/a) - Family ☐ Couples/Marital ☐ Domestic Violence ☐ Family – Child Related ☐ Family – Elder Care ☐ Family - Other ☐ Financial ☐ Legal	☐ Mandatory Referral ☐ Personal - Anger ☐ Personal - Anxiety ☐ Personal - Depression ☐ Personal – Eating Disorder ☐ Personal – Grief /Loss ☐ Personal - Interpersonal ☐ Personal - Medical ☐ Personal - Stress ☐ Personal - Other	☐ Positive non-DOT Test ☐ Substance Abuse ☐ Substance Abuse - Family ☐ Workplace - Career ☐ Workplace - Interpersonal ☐ Workplace - Stress ☐ Workplace - Transition ☐ Workplace - Violence ☐ Workplace - Other ☐ Other

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EAP Client Case Report

To be mailed or faxed, do not email

Client Name _____ Type of Session ☐ Individual ☐ Couple ☐ Family

Date of First EAP Session _____

Brief clinical observations and interventions

Is further EAP assessment indicated? ☐ YES ☐ NO Please Explain

Can problem resolution occur within EAP benefit? ☐ YES ☐ NO **(If NO, please make appropriate referral using client's insurance network and/or other resources available. Close Case Report and fax/mail with Billing Form.**

Date of EAP Session Type of Session ☐ Individual ☐ Couple ☐ Family

Clinical rationale for additional session within EAP

Brief clinical observations and interventions

Can problem resolution occur within EAP benefit? ☐ YES ☐ NO **(If NO, please make appropriate referral using client's insurance network and/or other resources available. Close Case Report and fax/mail with Billing Form.**

Date of EAP Session Type of Session ☐ Individual ☐ Couple ☐ Family

Clinical rationale for additional session within EAP

Brief clinical observations and interventions

If EAP client's benefit allows additional sessions for problem resolution you must complete brief clinical observations and interventions for each session. You may use an additional Case Report for those purposes.

Closing Recommendation:

☐ Additional EAP Counseling
☐ Inpatient Program
☐ Outpatient Counseling
☐ Psycho Educational Material / Self Help
☐ Referral to Spiritual Resource
☐ EAP Counseling only
☐ Intensive Outpatient / Partial Day
☐ Medical Assessment
☐ Referral to Legal / Financial Resource
☐ Referral to Community Resource

If referral was made, referred to:

Any self-referral for ongoing counseling must be pre-approved by an EAP counselor by calling 1-800-769-9819.

Signature of Counselor Providing Service: Date