ECU Health Employee Assistance Program

Supervisory Referral Form

Before making a Supervisory Referral, please call **252-847-4357** or **877-843-7207** and then fax the completed form to **252-847-7843.**

Name of EAP Counselor the Supervisor consulted with prior to referral:

Both parties must sign and date the form before returning to EAP office

Company Name: Location:
Department: Phone:
Referring Party: Job Title:

Name of Team Member Referred: Team Member ID#

Team Member Phone: Team Member Preferred Email:

Reason for Referral (complete or attach documentation describing reason/job performance issues). Please include workplace problem, time problem existed, what has been done to address the problem:

Has Human Resources been contacted: ☐ Yes ☐ No
Has Corrective Action been implemented: ☐ Yes ☐ No
Team Member to call EAP office within 3-business days of meeting with manager - Date:
Team Member to have an appointment within 5-business days of their call to EAP office - Date:

To the Team Member: By signing this form, you are allowing ECU Health EAP to release the following information:

Attendance and Appointment Scheduling

To the following person(s):

Name	Title	Email

Relation of above person(s) to client: _____

This release expires on the following date: _____ **Maximum 1 Year**

Authorization

This authorization for use or disclosure of information is being authorized by me giving ECU Health EAP permission to disclose information (listed above) obtained in the course of assessment. I understand that the information to be released is appointment date, time & attendance to EAP.

Team Member's rights:

- You may revoke this Authorization at any time by submitting a written revocation to ECU Health EAP
- A revocation will not apply to information that has already been used or disclosed in reliance on this authorization.
- You will be provided with a copy of this authorization form upon completion and execution if requested.

Signature of Referring Party	Date	Signature of Team Member	Date

Edited: 6/2022