MATRIX

EAP CLOSURE SUMMARY

Client No· _____ Therapist _____

Name _____ Closure Date _____

Employer _____ Date of Last Appt· _____

Additional persons attending sessions _____ Total # EAP Sessions _____

Check one:

__ No further therapy required __ Continuing with same doctor under insurance __ Referral to an outside resource

Please list all names of outside referrals:

_____

_____

Check all appropriate categories:

Counselor/SW (1) ___ Psychologist (6) ___ I/P Special Care Facility (11) ___
O/P Special Care (2) ___ I/P MH Facility (7) ___ O/P MH Facility (12) ___
Psychiatrist (3) ___ Physician (8) ___ Community Health Agency (13) ___
Hospital (4) ___ Self-Help Group ___ Attorney (14) ___
Financial Counselor (5) ___ Social Service Agency (10) ___ Other (15) ___

Outcome Evaluation:

Problem resolved ____ (1)
Problem improved ____ (2)
Problem unimproved ____ (3)
Assistance refused ____ (4)
Not disclosed ____ (5)

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Job Impairment after EAP Sessions:

Performance improved _____ (1)
Performance unimproved _____ (2)
No longer employed _____ (3)
Not applicable _____ (4)

If this patient's health plan requires pre-authorization from Matrix, please attach the appropriate case review form.

Return to:
Matrix
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