EAP ASSESSMENT FORM

NAME OF PATIENT _____ NAME OF EMPLOYEE _____

REFERRED BY _____

PRIMARY CARE PHYSICIAN _____ INSURANCE _____

REASON FOR EAP REFERRAL _____

_____

DATE OF INITIAL EAP ASSESSMENT _____

PROBLEM ANALYSIS AND SUMMARY _____

_____

ESTIMATE OF ADDITIONAL SESSIONS REQUIRED _____

TREATMENT RECOMMENDATIONS _____

REFERRAL RECOMMENDATIONS (IF APPLICABLE) _____

COMMENTS _____

_____

_____

THERAPIST NAME _____ DATE _____

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