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 _____
O/P Special Care_____
Psychiatrist _____
Hospital _____
Financial Counselor _____
Psychologist _____
I/P MH Facility _____
Physician _____
Self-Help Group _____
Social Service Agency _____
I/P Special Care Facility _____
O/P MH Facility _____
Community Health Agency _____
Attorney _____
Other _____

***O*utcome Evaluation:**

Problem resolved _____
Problem improved _____
Problem unimproved _____
Assistance refused _____
Not disclosed _____

Job Impairment after EAP Sessions:

Performance improved _____
Performance unimproved _____
No longer employed _____
Not applicable _____

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

Return to:

Matrix
2 Easton Oval, Suite 450
Columbus, OH 43219
Fax: 614-475-9821