Carilion EAP

**MANDATORY ALCOHOL AND DRUG REFERRAL**

**\*Please contact Carilion EAP immediately if employee expresses self-harm or harm to others\***

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| **Email form to:****EmployeeAssistanceProgram@carilionclinic.org****Fax form to: For EAP Consultation****540-981-8957 1-800-992-1931** |

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|  **This is the required form to FAX or EMAIL to Carilion EAP to register an employee who has violated your organization’s Drug Free Workplace Policy. We will make assessment arrangements once this form has been received in our office. Please complete all pertinent information. THIS FORM IS CONFIDENTIAL.** |

CHECK ONE: [ ]  DOT/CDL [ ]  NON-DOT

|  |  |
| --- | --- |
| **Company:** Click here to enter text. | **Company contact name:** Click here to enter text. |
| **Contact’s #:** Click here to enter text. | **Fax#:** Click here to enter text.[ ]  **Please notify before faxing** |
| **Date Completed:** Click here to enter a date. |

**The following employee needs an alcohol and drug assessment scheduled:**

|  |  |
| --- | --- |
| **Employee:** Click here to enter text. | **Date of Birth:** Click here to enter text. |
| **Social Security #:** Click here to enter text. |
| **Address:** Click here to enter text. |
| **City:** Click here to enter text. | **State:** Click here to enter text. | **Zip:** Click here to enter text. |
| **Work #:** Click here to enter text. | **Cell #:** Click here to enter text. |
| [ ] Client to call EAP for appointment | [ ] Request EAP to call client for appointment |

Summary of the Violation: Click here to enter text.

**Positive Drug/Alcohol Screen Information:**

**Type of Test:** [ ]  Random [ ]  Probable Cause [ ]  Post-accident [ ]  On-going Monitoring

 [ ]  Pre-employment

Date of Test: Click here to enter text. Tested Positive For: Click here to enter text.

Test Levels: Click here to enter text.

Has the employee been suspended? [ ]  Yes [ ]  No

If yes, start date Click here to enter a date. Probable end date Click here to enter a date.

**Additional Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**EMPLOYEE REVIEW:** I acknowledge that I have reviewed the content of this form and accept a referral to Carilion EAP. I authorize Carilion EAP to release to the designated supervisor or EAP Coordinator the following general information:

1. That I did or did not keep the initial appointment as arranged or rescheduled.
2. That a problem or issue was or was not identified through the assessment.
3. That I will or will not continue sessions or follow the recommendations of Carilion EAP.

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| Signature of Supervisor Date | Signature of Co./Org. EAP Coordinator Date |
| Signature of Employee Date | [ ]  Employee refused to sign review statement |