Chemical Assessment Referral and Release to VITAL WorkLife

Phone 1.800.383.1908 **or** 320.253.1909
Fax 320.240.1501

Employee _____ Phone _____

Employer _____

Employer Contact _____ Phone _____

E-mail _____

Other Contact(s)_____ E-mail _____

Positive Test for: _____ Date: _____ Level(s) if known: _____

Please describe, as specifically as possible, why the employee is being referred. What specific changes are being required? *Attach additional information that would be helpful for the counselor to address your work performance concerns, e.g. Performance Improvement Plans, written warnings, previous corrective action, etc.*

_____

_____

_____

_____

Are there any specific requests or information sought by the employer following the assessment, e.g. required number of sessions with the counselor, specific testing schedule, negative UA test in order to return to work, etc.?

_____

_____

_____

_____

The employee is expected to contact VITAL WorkLife by _____ (date) to initiate setting up an appointment.
By signing this form, the employee authorizes VITAL WorkLife and/or contracted consultant to release and/or exchange pertinent information with their employer. If the employee fails to follow through with the appointment, Midwest will notify the employer.
Information to be disclosed: ***Please strike out and initial any area you revoke to be disclosed.***

- Attendance at EAP counseling session(s) at VITAL WorkLife and/or contracted consultant
- Engagement, investment and cooperation of employee throughout the EAP process/services being offered
- Skill building being addressed and progress toward behavior change
- Recommendations of Midwest EAP Counselor and/or contracted consultant

I understand that I may refuse to sign this consent, but that refusal may have consequences which have been explained to me by my employer. I understand that I may revoke this consent at any time and that this consent expires upon fulfillment of the above indicated purpose(s) or one year after signature date, whichever occurs first. I understand that revoking my consent may have consequences also.

Employee Signature _____ Date _____

Employer Representative _____ Date _____

(see reverse)

Counselor: Please complete and fax to VITAL WorkLife
no later than 3 days after all EAP sessions are concluded.
Attach additional information as necessary.

Session Dates: _____ _____ _____ _____ _____ _____

Areas addressed and progress toward each area:

_____

_____

_____

Skill Building Addressed/Assigned:

_____

_____

_____

Recommendations for continued Counseling, if applicable (check all areas that apply):

_____ * Participation in Community Support Groups: AA/NA (List location information and number of meetings)

_____ * Outpatient chemical dependency treatment (List program information)

_____ * In-patient chemical dependency treatment (List program information)

_____ * Participation in Alcohol/Drug Education Class (List program information/resources)

_____

_____

_____

Recommendations for the Employer (check all areas that apply):

_____ * Return to duty with minimum requirements of responsible use of alcohol and no illegal drug use

_____ * Recommended re-test date based on self-report of last use:_____

_____* Recommended testing schedule (frequency and time frame, e.g. 3 times per month for the first month, then once a month for 6 months):_____

_____

_____

_____

Counselor Signature Date

Revised 12/5/14