



**Performance Based Referral and Release  
to VITAL WorkLife, Inc.**  
Phone 1.800.383.1908 or 320.253.1909  
Fax 320.240.1501

Employee \_\_\_\_\_ Phone \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Employer Contact \_\_\_\_\_ Phone \_\_\_\_\_  
 \_\_\_\_\_ Email \_\_\_\_\_  
 Other Contact(s) \_\_\_\_\_ Email \_\_\_\_\_

This employee has been referred to VITAL WorkLife Employee Assistance Program as part of a performance improvement plan. This referral is viewed as an opportunity for the employee to receive assistance from the EAP to assess barriers to meeting performance expectations, and to develop an action plan to be successful in meeting the expectations required by the employer.

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 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 and counseling, e.g. required number of sessions with the counselor, specific documentation needed, 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, VITAL WorkLife will notify the employer.

Information to be disclosed: ***Please strike out and initial any area you do not allow 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 VITAL WorkLife 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:

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Skill Building Addressed/Assigned:

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Recommendations for continued Counseling, if applicable:

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Recommendations for the Employer:

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\_\_\_\_\_  
Counselor Signature

\_\_\_\_\_  
Date