Preferred EAP
When you need to talk... there's someone to listen.

NATIONAL NETWORK PROVIDER'S REPORT

CLIENT FULL NAME: _____

PEREFRRED EAP#: _____

PROVIDER NAME: _____

DATE OF REPORT: _____

DATES OF SERVICE: _____

ASSESSMENT INFORMATION

- IDENTIFIED PROBLEM(S): _____

  _____

  _____

- SYMPTOMS OF IDENTIFIED PROBLEM(S) (please be specific): _____

  _____

  _____

  _____

  _____

  _____

- IS THIS CLIENT AT RISK FOR SUICIDE OR HOMICIDE? IF YES, PLEASE EXPLAIN:

  _____

  _____

→ ***OVER***

- SUBSTANCE ABUSE HISTORY: _____

  _____

  _____

- MEDICATIONS: _____

  _____

- BEHAVIORAL HEALTH TREATMENT HISTORY (IP & OP / WHEN, WHERE, DIAGNOSES):

  _____

  _____

  _____

  _____

REFERRAL & OUTCOME INFORMATION

- OUTCOME
  _____ SERVICE COMPLETED, TERMINATED BY MUTUAL AGREEMENT
  _____ SERVICE NOT COMPLETED, CLIENT DROPPED-OUT
- PROGNOSIS: _____
- WAS THE CLIENT REFERRED FOR CONTINUED CARE? ___ YES ___NO
  - IF YES, TO WHOM: _____
    - PHONE: _____
  - LINKAGE CONFIRMED? __YES __ NO ___ UNKNOWN

ADDITIONAL COMMENTS

_____

_____

_____

_____

_____

_____