Family Services EAP
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Lawrence, MA 01840

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Family Services EAP
Supervisor Referral Form

Company Name: _____

Date of Referral: _____

Type of Referral (Please check):

- ☐ Formal – (Performance/attendance/lateness related)
- ☐ Mandatory – (Conduct/safety/drug-alcohol related)

Employee Name: _____**Title**: _____

Employee Phone: _____

Company Representative: _____**Title:** _____

Phone: _____ **Fax:** _____

Reason for Referral (please specify duration of existing problem and steps taken):

_____

_____

_____

_____

Company Representative: _____ _____
Signature Date

EAP WILL FAX FORM BACK TO THE COMPANY AFTER 1ST VISIT IF THERE IS A **SIGNED RELEASE** OF INFORMATION.

FOR STAFF USE ONLY

Family Services Staff: _____ **Date of 1st visit:** _____