



**EMPLOYEE ASSISTANCE PROGRAM
MANAGER REFERRAL FORM**

Date _____
Facility _____ Department _____
Manager/Supervisor _____ Contact Telephone _____
Employee Name _____ Employee Contact Telephone _____
This referral of _____ to the Employee Assistance Program

is made to assist the above employee in correcting the following work related concerns:

Please check item(s) that apply:

- | | |
|---|--|
| <input type="checkbox"/> Quality of Work | <input type="checkbox"/> Interpersonal Relationships |
| <input type="checkbox"/> Absenteeism | <input type="checkbox"/> Productivity |
| <input type="checkbox"/> Tardiness | <input type="checkbox"/> Positive Drug Screen |
| <input type="checkbox"/> Other (please explain) _____ | |

This referral is Voluntary Mandatory, however, it is understood that improvements in job performance are expected. It is also understood that External EAP or any other recommended treatment provider will inform the Broward Health EAP manager of employee's participation in the EAP. Such information will be limited to whether the employee kept their appointment and whether they have followed through with the counselor's recommendations for help.

This referral has has not been reviewed with Human Resources.

I understand that this limited information will be shared with my manager. If written or final corrective actions has been initiated, Human Resources may also be made aware of this referral.

Name of Employee

Name of Manager/Supervisor

Signature of Employee

Signature of Manager/Supervisor

Date

*Manager/Supervisor:

Please call the EAP office, at 954.847.4EAP to discuss this referral.

White - Managers

File: Yellow - Send to EAP office - District

Pink - Employee to take to counselor's office