



Employee Assistance Program

Case Closing Summary Form

Client Name: _____

D.O.B. _____

DESCRIPTION OF PROBLEM AND CLIENT:

PERTINENT INFORMATION:

INTERVENTIONS:

FUTURE PLAN:

EAP OUTCOME (Decision made at the end of EAP consultation sessions. Check one box only)

EAP CONSULTATION ONLY

- Community Education
- No Further Treatment (EAP 1-3 only)

OTHER EAP SERVICES

- EAP Short Term Sessions
- Child Care
- Financial
- Legal
- Elder Care

TREATMENT REFERRAL- *specify for all below*

- Outpatient
- Inpatient
- Partial
- Residential

TREATMENT REFERRAL: PROVIDER INFORMATION (ONLY if referring into insurance billable treatment)

(Copy this form if additional referrals needed for Behavioral Health Management)

Clinician: _____ Credentials: _____

Clinic: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Have you verified that the above provider will be covered by Client's health benefits? Yes No

AUTHORIZATION TYPE - CHECK ONLY ONE. (Complete for Access or Behavioral Health Management companies when there is an outpatient referral. See contract information on the Intake Information sheet)

Company Name _____ Access Behavioral Health Management - Provisional Diagnosis: _____

FOLLOW-UP	YES	NO	NA
Date:			
Contact Type: <input type="checkbox"/> Phone <input type="checkbox"/> Letter <input type="checkbox"/> Voice Mail <input type="checkbox"/> EMail <input type="checkbox"/> Client will call back as needed			
<i>Chart any follow up in the progress notes.</i>			

Signature EAP Assessment Counselor/ Affiliate _____

Case Closure Date _____