CARE
WORKLIFE SOLUTIONS

CARE'S WORKLIFE SOLUTIONS FORMAL REFERRAL FORM

This form MUST be completed and submitted to CARE's WLS in order for an employee's information to be disclosed to the company.
Employees presenting to CARE's WLS without this form will be processed as self-referrals.

Today's Date: _____ Company Name:_____

Name of Referring Person or Persons*: _____

Phone:_____ Fax:_____

Address: _____

Referring person MUST be the primary or secondary contact the company has previously identified as liaison for employee assistance. CARE's WLS will only release information to this person.

Type of feedback desired:
❒Confirmation of assessment at CARE's WLS ❒Attendance and progress
❒Confirmation of admission to services/treatment ❒Discharge status

Employee's Name:_____ Employee's Job Title:_____

Reason for Referral: Please identify all documentable job performance issues.

❒Absenteeism/tardiness ❒Disruption of workplace ❒Decline in performance

❒Failed alcohol/drug screen ❒Failed DOT drug test

Date: _____Substance:_____ Date:_____ Substance:_____

❒Other_____

_____

_____

Is a signed release of information attached? ❒Yes ❒No

Please include any additional information, such as last chance agreement, that may be helpful in assessing the situation. Please note that all information provided becomes part of the legal record and may be shared with the client.

Submit completed form to CARE's WLS by fax: 586-541-2274

_____

Signature of primary or secondary contact person

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

1. I, _____, authorize **CARE's WorkLife Solutions**

to disclose to _____
(Name of person or organizations to which disclosure is to be made)

The following information: Confirmation of appointments, confirmation of assessment/referral,

acceptance of recommendations, and/or _____.

The purpose of the disclosure authorized herein is: per clients request to comply with employer's request.

I further authorize _____
(Name of person or organization making disclosure)

to release to CARE's WorkLife Solutions (Name of person or organization to which disclosure is to be made)

the following information: Reason for referral, specific back-to-work stipulations, if any.

The purpose of the disclosure is: per clients request to assist with determination of treatment needs.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CRF Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45CFR Pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

6 Months after either notification of failure to enter treatment or confirmation of discharge

_____
(Specification of the date, event or condition upon which this consent will expire)

Dated:_____ _____
(Signature of Client)

_____
(Signature of parent, guardian or authorized representative when required)

A photocopy/facsimile of the signed consent shall have the same force and effect as the client's original signature.

05.08.14 Employer

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