

HelpNet Formal Management Referral Form

Please fax or mail Formal Management forms, prior to your employee's scheduled appointment.

Fax: 269-245-3899 Phone: 800-969-6162

Mail: 36 W. Manchester Ave., Battle Creek, MI 49037

| | |
|--------------------------|---|
| Employee Name | Company Name |
| Employee Position | Safety/Security Sensitive (Circle one) Yes No |
| Employee Home Phone | Employee Work Phone |
| Appointment Day and Date | Appointment Time |

Supervisor's evaluation of employee's behavior and work performance based on the criteria listed below. Circle the response from (N/A) to (5) which most appropriately describes your level of concern. **For any concerns rated 3 or higher, specific examples of problem behaviors are required. Please attach a separate page.**

| | | | Little Concern | | Moderate Concern | | Serious Concern |
|----|--|-----|----------------|---|------------------|---|-----------------|
| 1 | Absenteeism Describe (Specify Frequency, Intensity, Duration) | N/A | 1 | 2 | 3 | 4 | 5 |
| 2 | Tardiness and/or Leaving Early Describe (Specify Frequency, Intensity, Duration) | N/A | 1 | 2 | 3 | 4 | 5 |
| 3 | Observance of Work Hours Lunch, Breaks, Vacation, Sick leave Describe (Specify Frequency, Intensity, Duration) | N/A | 1 | 2 | 3 | 4 | 5 |
| 4 | Quality of Work Describe | N/A | 1 | 2 | 3 | 4 | 5 |
| 5 | Quantity of Work Describe | N/A | 1 | 2 | 3 | 4 | 5 |
| 6 | Safety Record Accidents, Injuries on the Job Describe (Specify Frequency, Intensity, Duration) | N/A | 1 | 2 | 3 | 4 | 5 |
| 7 | Erratic Disruptive Behavior Excessive Complaining, Aggressive Behavior, Actions Disturbing Other Employees, Rule Violations, etc. Describe (Specify Frequency, Intensity, Duration) | N/A | 1 | 2 | 3 | 4 | 5 |
| 8 | Acceptance of Supervision Attitude, Willingness to Follow Instructions, Insubordination, Etc. Describe (Specify Frequency, Intensity, Duration) | N/A | 1 | 2 | 3 | 4 | 5 |
| 9 | Personal Presentation Appearance, Impression Given to Public, Communication Skills, Etc. Describe (Specify Frequency, Intensity, Duration) | N/A | 1 | 2 | 3 | 4 | 5 |
| 10 | Other Behavior Unique to Employee Illness, Off-the-Job Injuries, Garnishments, Anything not Previously Covered Describe | N/A | 1 | 2 | 3 | 4 | 5 |

Fax Previous Disciplinary History: 269-245-3899

| Date of Discipline | Verbal/Written/Termed | Reason for Discipline |
|--------------------|-----------------------|-----------------------|
| | | |

What behavioral changes/improvements do you expect from this employee in the future? _____

*If needed, please attach additional sheet(s) to describe the situation in greater detail.

| | |
|-------------------------|---------------------|
| Employer/H.R. Signature | Date |
| Employer/H.R. Phone # | Employer/H.R. Fax # |

I certify that I have reviewed the content of this referral form, and that I accept a referral to the EAP.

Signature of Employee: _____ **Date:** _____

**HelpNet Employee Assistance Program
Formal Management Referral Client Release Authorization**

I, _____, hereby authorize HelpNet Employee Assistance Program, its clinical director or designee,
(Client's Name Printed)
to obtain and/or release information in my client records to the individual or organizations listed and only under the conditions listed below:

1) Name of person(s) to whom disclosure is to be made:

2) Specific type of information to be disclosed: **Attendance**

3) The purpose and need for such disclosure:

X Attendance And Compliance For Formal Management Referral

4) I hereby consent to the release of any medical information, which may include the following: PSYCHIATRIC, ALCOHOL and/or DRUG ABUSE RECORDS, AIDS, AIDS-RELATED COMPLEX (ARC) and HIV INFECTION.

5) This patient consent form is in accordance with Public Act 56 1973 and in compliance with Title 42 of Federal Regulation Part II. It is also in accordance with Public Act 174.

6) A photocopy or fax of this signed consent form shall have the same force and effect as the client's original signature.

7) I understand that this authorization may be withdrawn by me at any time with written notice. Revocation of this authorization will not affect any information already released. This authorization shall expire without express revocation one year (12 months) from the date written below.

8) I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

Client Signature Date

Parent/Guardian Date

Client Printed Name

Witness/Human Resources Signature Date

Relationship to Client

Witness/Human Resources Printed Name