EMPLOYEE ASSISTANCE PROGRAM
ASSESSMENT / TREATMENT PLAN

CLIENT NAME: ____________________________________  COMPANY: ________________________________
EAP COUNSELOR’S NAME: (Please print) ________________________________  Your Agency: ________________________________
Agency City: ___________________  Phone No: ________________________________

INITIAL SESSION INFORMATION

DATE 1ST SESSION _________  Number of people seen in session? ______
Recent suicidal or homicidal intent or plan?  ☐ Yes  ☐ No (If yes, please contact us.)
Recent physical or sexual abuse?  ☐ Yes  ☐ No (If yes, please contact us.)
Primary Assessed Issue: ________________________________  Secondary Assessed Issue: ________________________________
Therapy Type: ☐ Individual  ☐ Couple  ☐ Family

EAP COUNSELING SESSIONS REQUESTED

Please check one of the following:
☐ Additional EAP sessions are requested  Number of Sessions: ______
☐ Client refused recommendations no sessions requested
☐ Only one assessment session needed  ☐ Client referred to long term treatment

TREATMENT FOCUS

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<tr>
<th>Problem</th>
<th>Goals/Objectives</th>
<th>Intervention</th>
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REFERRING BEYOND EAP

A referral beyond EAP is needed: ☐ Yes  ☐ No
(If so, please check the following)
☐ AODA Outpatient  ☐ AODA Inpatient  ☐ Outpatient Mental Health  ☐ Inpatient Mental Health
Other (please specify):

Non-treatment Services: ☐ Legal  ☐ Financial  ☐ Medical  ☐ Occupational  ☐ Other: ________________________________
Agency Referred To:
Provider: ____________________________________  Provider: ____________________________________
Address: ____________________________________  Address: ____________________________________
Phone: ____________________________________  Phone: ____________________________________

Notice: If client is to continue to receive services (beyond the scope of EAP) at the Affiliate which will be charged to insurance, the Freedom of Choice information on the Closing Form must be signed and sent to ThedaCare EAP.

EAP Counselors Signature: ________________________________  Date: __________________

** PLEASE FAX THIS FORM TO THEDACARE EAP WITHIN 72 HOURS OF SEEING THE REFERRED CLIENT(S). **

Fax Number: 920-749-2399  Phone numbers: 920-749-2390 * 1-800-236-3666