SUPERVISOR REFERRAL FORM

For Mandatory Referrals To The

EMPLOYEE ASSISTANCE PROGRAM

Note to the Supervisor: If this is your first time to make a mandatory referral to the EAP and you have questions, please call **806-743-1327**.

SUPERVISOR AND EMPLOYEE INFORMATION

Please print

Employee's Name: _____ Referral Date: _____

Employer: _____

Department (if applicable): _____ Employee's Phone: _____

Referring Supervisor's Name: _____ Title: _____

Supervisor's Phone (work /cell): _____ Confidential Voice Mail? ☐ Yes ☐ No

Supervisor's E-Mail: _____

REASON FOR REFERRAL

Please indicate the reason(s) for this referral (*check all boxes that apply*).

☐ **JOB PERFORMANCE PROBLEMS**

- ☐ Lower quality of work
- ☐ Decreased productivity
- ☐ Increased errors
- ☐ Erratic work patterns
- ☐ Failure to meet schedules
- ☐ Attendance
  - ☐ Excessive tardiness
    Days late in past month: ____
  - ☐ Excessive absence
    Days absent past 3 months: _____
  - ☐ Other _____

☐ **SUBSTANCE ABUSE PROBLEMS**

- ☐ Failed random ***drug*** or ***alcohol*** test. (*Please circle which one*.)
  Does the Employee have a CDL? ☐ Yes ☐ No
- ☐ Post-accident failed drug or alcohol test
- ☐ Under the influence at work
- ☐ Meets criteria for reasonable suspicion

☐ **BEHAVIORAL CONCERNS**

- ☐ Avoids supervisor/coworkers
- ☐ Less communicative
- ☐ Unusually sensitive to feedback
- ☐ Unusually critical of others
- ☐ Conflict with co-workers
- ☐ Disregard for safety
- ☐ Frequent mood swings (high or low)
- ☐ Loss of interest
- ☐ Impaired judgment/memory
- ☐ Inability to concentrate

- continued -

VIOLENCE ISSUES

☐ Threatened/intimidated others at work
☐ Domestic violence
☐ Harassment

Please attach additional comments and/or supporting documentation for any of the above concerns.

SUPERVISOR PERFORMANCE GOALS

1. Have the issues marked on this form been discussed with the employee? ☑ Yes ☐ No
2. What are the consequences if employee performance does not improve?
3. Have the consequences for not improving been discussed with the employee? ☐ Yes ☐ No
4. How will the employee's improvement be measured? *(Please be as specific as possible.)*
5. How long will the employee be given to make the desired changes?

EMPLOYEE SIGNATURE

I understand that my supervisor is referring me to the Employee Assistance Program and my signature verifies that I have seen this form. My signature below does not signify my agreement or disagreement with any of the issues raised.

☐ Yes, I ***will*** participate in and cooperate with the Employee Assistance Program.
☐ No, I ***will not*** participate in the Employee Assistance Program.

_____ _____
Signature of employee Date

Please forward this form by email, fax, or regular mail to:
counselingcenter@ttuhsc.edu
The Counseling Center at TTUHSC
Texas Tech University Health Sciences Center
3601 4th Street – STOP 8119
Lubbock, TX 79430-8119
Phone: 806.743.1327 or 1.800.327.0328
Fax: 806.743.7301
