Employee Assistance of the Pacific
Referral Form for DOT-SAP and non-DOT Assessments

TO BE COMPLETED BY SUPERVISOR OR PERSONNEL OFFICE *(Incomplete forms may result in delay of evaluating employee)*

Employee Name:	Position:	Bargaining Unit:

Company:

Department:	Division:

Designated Employer Representative (DER):	Company Phone:

Email Address:

Mailing Address:

Alternate (DER):	Phone:	Email:

Employee's Home Address:

Home Phone:	Mobile Phone:	Business Phone:	Birth date:	Last 4 SSN (DOT only):

☐ Random   ☐ Voluntary Admission – See notes below under supervisor comments   ☐ Return to Duty
☐ Pre–employment (or transfer to safety-sensitive duties)   ☐ Reasonable Suspicion   ☐ Post-Accident   ☐ Follow-Up

Date of Test:	Drug Test Positive For:	☐ Breath Alcohol Positive ☐ BAL:_____

☐ Non – DOT Test	☐ Federal DOT Test – also check DOT mode: ☐ FMCSA ☐ FTA ☐ USCG ☐ FAA ☐ FRA ☐ PHMSA

For FMCSA/CDL Drivers: CDL Number: State of Issuance:

Previous Test Results – List Type: Random, Reasonable Suspicion, Post-Accident, Follow-up, Pre-employment	Date:	Results: (Negative or Positive & Substance)

Supervisor's Comments (pertinent facts and history including attendance and behavior)

Status: ☐ LWOP   ☐ Suspension of _____ days, then eligible to use: ☐ Sick Leave (_____ days available, if known)
☐ Suspension Pending Completion of SAP Process   ☐ Vacation Leave (_____ days available, if known)

Beginning date of suspension, if applicable: _____   Ending date of suspension, if applicable: _____

Please complete and scan/email this form to us (info@eapacific.com) or fax to 808-597-8230 before the employee calls us so that we may schedule an appointment with them.
If there is additional information you would like to provide us, please call us at 597-8222.
It is the employee's responsibility to call us! *If this a **Non-DOT referral**, please add your company information in page 2, have the employee sign page 2, and include it with the referral.*

Authorization for Release of Protected Health Information
(Not Needed for DOT-SAP Referrals)

I, _____, DOB:_____ authorize the use and disclosure of protected health information as described below:

☒ **A mutual release and sharing of information BETWEEN the individual/organization listed below and Employee Assistance of the Pacific**

☐ **Release of information TO the individual/organization listed below from Employee Assistance of the Pacific**

☐ **Request of information FROM the individual/organization listed below to Employee Assistance of the Pacific**

Name and/or Organization: _____

Address:_____ City/State/Zip:_____

Phone:_____ Email:_____

The reason why this information should be released is:

☒ At my request   ☒ Determine need and type of treatment/education

☒ Attendance and participation with EAP, EAP recommendations, and compliance with recommendations

☒ Care coordination/management   ☐ Other_____

This authorization includes the release of the following:

☒ Diagnosis and/or treatment for alcohol use or dependency and/or drug abuse or dependency

☐ Diagnosis and/or treatment of mental illness

☐ HIV antibody test results and/or AIDS diagnosis and treatment

☐ Genetic testing information

☐ _____

This authorization shall be in force and effect for **1 year** or until I revoke it in writing, or until _____, whichever is shorter.
(insert expiration date or event)

By my signature below, I understand my rights:

- I understand that my records are protected under Federal and State confidentiality laws and regulations and may not be disclosed without my written consent unless otherwise provided for in the regulations.
- "Employee Assistance of the Pacific" includes its staff, affiliate providers, and consultation vendors.
- I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.
- I have a right to request a copy of this form and to request a copy of the information that is being disclosed.
- This release is voluntary and I do not have to sign this authorization.
- Information may be released in written, verbal, and/or electronic format.
- I understand that if the information authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. I have the right to seek assurances from such recipient of my information that they will not redisclose the information to any other party without my further authorization. Employee Assistance of the Pacific will not be held liable for any redisclosure of protected health information by such recipient.
- I acknowledge that this information to be released was fully explained to me and this consent is given of my own free will.

Date: _____   Signature: _____   Phone: _____

If signed by other than patient or parent of minor child, please print name and indicate relationship. Submit documents to show authority to request information on this individual.

Print: _____   _____
Authorized representative's name   Relationship to Client