Fax to: Kaitlin Blanco-Silva at 803-929-0762

POST ASSESSMENT SUMMARY

Due on completion of assessment

Please notify EAP immediately of any failure to comply or failure to attend sessions. 803-929-0661

RE: PATIENT ____ DOB: ______________________________

Date of Assessment: __________________________________Diagnosis:________________________________

Treatment recommendations: (select all that apply)

☐ Individual Counseling ☐ Education/Therapy Group ☐ IOP ☐ Family Counseling ☐ Group Counseling

☐ In-patient ____

☐ Referred Out ____

Start Date of Tx: ___________________ Frequency: _____________________ Estimated End Date: _______________

If in group, circle the days the group meets: Sun Mon Tue Wed Thurs Fri Sat

If group, time of group meetings: ________________________________

Typical session length__________________________ Projected number of sessions needed: _______________________

Drug screen: Date of screen: _______________________ Results: ____

Counselor Impressions:

Counselor's Signature:_______________________________Credentials:______________________

Counselor's Phone Number: __________________________Date:____________________________

Counselor's Address:____