Palmetto EAP
UR FORM

TREATMENT PROVIDER:

PATIENT _____ DOB _____

ADDRESS _____ PHONE _____

I understand and give permission for this information to be provided to Palmetto EAP for general statistical purposes only. Palmetto EAP is subject to all applicable Federal and State Confidentiality Laws.

_____ _____

Patient's Signature (or legal guardian, if underage) *Job Title - (Leave blank if you are a dependent)*

Are you?		AGE			Race:
Employee	☐	under 18	☐	46-55 ☐	
Dependent	☐	18-25	☐	56-65 ☐	If you are a dependent, what is the name of the family member with the EAP benefit?
Male	☐	26-35	☐	over 65 ☐	
Female	☐	36-45	☐		

WHAT PROBLEMS ARE YOU HAVING? CHECK ALL THAT APPLY

Marital/Relational	☐	Sexual	☐	Addictions: Substance, sex, exercise, compulsive overeating, shopping, compulsive internet use, gambling	☐	Other:
Sleep Problems	☐	Depression	☐			
Impulse Control	☐	Legal	☐	Poor decision making	☐	
Financial	☐	Child &		Confusion	☐	
Anxiety	☐	Parenting	☐	Medical/Health	☐	
Bullying (work, school)	☐	Other Family	☐	Appetite Problems	☐	
Grieving a Loss	☐	Job	☐	Thoughts of hurting self or		
Anger	☐	Confusion	☐	others	☐	

JOB CATEGORY

A Dependent	☐	Support Staff	☐		
Professional	☐	Technical	☐	Executive/CEO	☐
Service/Sales	☐	Manager/Supervisor	☐	Production or Labor	☐

LENGTH OF SERVICE TO YOUR EMPLOYER

A Dependent	☐	6-10 years	☐
Less than 1 year	☐	11-20 years	☐
1-5 years	☐	Over 20 yrs.	☐

REFERRAL ROUTE

Self Referral ☐

Mandatory Referral ☐ (You were required to enter EAP services)

HOW DID YOU LEARN OF YOUR EAP BENEFIT?

Company Orientation	☐	Supervisor	☐	Human Resources	☐
EAP posters,brochures	☐	Medical Department	☐	Union Rep	☐
CoWorker	☐	Family Member	☐	Former client	☐
				Other:	

WHICH EMPLOYER PROVIDES THE EAP BENEFIT TO YOU? **(This is the company the employee works for, not dependent)**

Note to the Patient: If this form is not COMPLETELY filled out, your EAP sessions may not be reimbursed. ***Form Rev 9/28/15***