

NEW AVENUES EMPLOYEE ASSISTANCE PROGRAMS

P.O. Box 360 South Bend, IN 46624
Phone: 866-925-5730 Fax: 574-271-5980

Initial EAP Assessment – Routine – Level I

Fax after 1st session to New Avenues

Client Name: _____ Date of Birth: _____ Other Family Members: _____ _____ _____	Date of Assessment: _____ Employee Name: _____ Social Security #: _____ Occupation: _____ Employer: _____
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Referred by: Self Employer Friend Brochure Family Other
Type: Self-Referral Concerned Supervisor Other
 Referral Level: Routine Urgent Emergent

Client's Presentation of the problem:

Client's Expected Outcome:

Professional Assessment: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <i>Please use the checklist to identify client's strengths and resources as well as problems areas. These may be listed as evidenced by history and observation.</i> </div> <p>GAF Score: _____ Does the client exhibit symptoms that would be significant to meet clinical criteria of DSM-IV? If so contact the Care Mgr. for treatment planning.</p> <p>Is there serious current risk of? <i>If present – call New Avenues Care Manager ASAP</i></p> <p> <input type="checkbox"/> abuse or family violence <input type="checkbox"/> suicide, homicide or violence <input type="checkbox"/> psychotic or severe psychological disorder </p>	Strengths/Resources (√ if present) 1 - Adequate 2 - Above Average 3 - Exceptional <table style="width: 100%; border-collapse: collapse;"> <tr><td><input type="checkbox"/> Family Support</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Social Support Systems</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Relationship Stability</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Intellectual/Cognitive skills</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Coping Skills & Resiliency</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Parenting Skills (if applicable)</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Socio-Economic Stability</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Communication Skills</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Insight & Sensitivity</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Maturity & Judgment Skills</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Motivation For Help</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Other</td><td style="text-align: right;">1 2 3</td></tr> </table>	<input type="checkbox"/> Family Support	1 2 3	<input type="checkbox"/> Social Support Systems	1 2 3	<input type="checkbox"/> Relationship Stability	1 2 3	<input type="checkbox"/> Intellectual/Cognitive skills	1 2 3	<input type="checkbox"/> Coping Skills & Resiliency	1 2 3	<input type="checkbox"/> Parenting Skills (if applicable)	1 2 3	<input type="checkbox"/> Socio-Economic Stability	1 2 3	<input type="checkbox"/> Communication Skills	1 2 3	<input type="checkbox"/> Insight & Sensitivity	1 2 3	<input type="checkbox"/> Maturity & Judgment Skills	1 2 3	<input type="checkbox"/> Motivation For Help	1 2 3	<input type="checkbox"/> Other	1 2 3	Problem Areas (√ if appropriate) 1 - Mild 2 - Moderate 3 - Severe <table style="width: 100%; border-collapse: collapse;"> <tr><td><input type="checkbox"/> Family Conflict/Crisis</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Marital /Relationship</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Psychological/Emotional</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Child/Adolescent Behavior</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Work Performance</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Gambling</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Legal/Financial</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> School Performance</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Crisis Adjustment</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Sexual Abuse</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Trauma Victim</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Anger Management</td><td style="text-align: right;">1 2 3</td></tr> <tr><td><input type="checkbox"/> Other</td><td style="text-align: right;">1 2 3</td></tr> </table>	<input type="checkbox"/> Family Conflict/Crisis	1 2 3	<input type="checkbox"/> Marital /Relationship	1 2 3	<input type="checkbox"/> Psychological/Emotional	1 2 3	<input type="checkbox"/> Child/Adolescent Behavior	1 2 3	<input type="checkbox"/> Work Performance	1 2 3	<input type="checkbox"/> Gambling	1 2 3	<input type="checkbox"/> Legal/Financial	1 2 3	<input type="checkbox"/> School Performance	1 2 3	<input type="checkbox"/> Crisis Adjustment	1 2 3	<input type="checkbox"/> Sexual Abuse	1 2 3	<input type="checkbox"/> Trauma Victim	1 2 3	<input type="checkbox"/> Anger Management	1 2 3	<input type="checkbox"/> Other	1 2 3
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Overall Current Health: _____

Is person on any medications? If so, please list _____ **Prescribed by:** _____

_____ **Prescribed by:** _____

Prior Behavioral Health Treatment _____ **Date:** _____

Drug Alcohol Assessment	Substance(s)	Frequency & Amount of use	Treatment
Family History of substance use:	_____	_____	_____
Personal use:	_____	_____	_____
In Current primary relationships:	_____	_____	_____

Is substance use? Primary focus of treatment Contributing to current problems Not relevant Needs further Assessment

Treatment Plan:

Primary Goals: 1 _____ 2 _____

Outcomes Anticipated: List specific behaviors for individual or family to indicate progress and improvement:

Modalities to achieve outcome: Individual Family or couple therapy Group Assessment only
 Collateral contact with employer, school, etc. Psycho-educational program Referral to community resources

Anticipated Discharge Date: _____ **Anticipated # Sessions** _____

Anticipate: Resolution of current problems within the EAP
 Additional Behavioral Health Services - Psych. Eval. Psych. Testing Substance Abuse Treatment Other
 Community Referral - PCP Support Group AA or NA Social service agency Other

Optional: Please submit any additional information in an attached narrative that you feel may bear on this case.

Provider Signature _____ **Date:** _____