

NEW AVENUES EMPLOYEE ASSISTANCE PROGRAM

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eap_referral@newavenuesonline.com

EAP Case Closing Summary

Fax or (secure) email after final EAP session

Member Name:	Employee Name:
Date of Birth:	Employer:
Member ID/Policy #	Routine EAP Referral Management Referral
Assessment Date: Final EAP Session Date:	Member did not follow through with referral
Number of Sessions Held: Number of Cancellations:	Number of No Shows:
Disposition of Case at Closing:	
Goals Met: Yes No Improved	
Client discontinued EAP services.	
Recommended continued treatment beyond EAP. Ye	No Member Declined
Client was terminated from employment.	
Client quit their job and was no longer eligible for services.	
Presentation of the Concerns:	
Alcohol Use Depression Final Anxiety/Stress Domestic Violence Grie Child/Adolescent Drug Use Heal COVID-19 Family Lega	f or Loss Trauma th Work Stress/Occupational
Additional Resources Recommended:	
Ongoing Behavioral Health Services Psychiatric Evaluation Psychological or Neuropsychological Testing Substance Use Treatment Higher Level of Care i.e., Inpatient, PHP, IOP Other	Primary Care Physician Support Group Community Referral AA or NA Social Service Agency
Comments:	
Provider Signature: Print Name:	Date: