

SUPERVISOR REFERRAL FORM

For Mandatory Referrals To The EMPLOYEE ASSISTANCE PROGRAM

Note to the Supervisor: If this is your first time to make a mandatory referral to the EAP, please call **806-743-1327** and ask to speak to the EAP Director or Associate Director. Thank you.

SUPERVISOR AND EMPLOYEE INFORMATION

Please print

Employee's Name: _____ Referral Date: _____

Employer: _____

Department (if applicable): _____ Employee's Phone: _____

Referring Supervisor's Name: _____ Title: _____

Supervisor's Phone (work /cell): _____ Confidential Voice Mail? ☐ Yes ☐ No

Supervisor's E-Mail: _____

REASON FOR REFERRAL

Please indicate the reason(s) for this referral (*check all boxes that apply*).

☐ **JOB PERFORMANCE PROBLEMS**

- ☐ Lower quality of work
- ☐ Decreased productivity
- ☐ Increased errors
- ☐ Erratic work patterns
- ☐ Failure to meet schedules

☐ Attendance

- ☐ Excessive tardiness
Days late in past month: _____
- ☐ Excessive absence
Days absent past 3 months: _____
- ☐ Other _____

☐ **SUBSTANCE ABUSE PROBLEMS**

- ☐ Failed random *drug* or *alcohol* test. (*Please circle which one.*)
Is the employee in a safety sensitive position? ☐ Yes ☐ No
- ☐ Post-accident failed drug or alcohol test
- ☐ Under the influence at work
- ☐ Meets criteria for reasonable suspicion

☐ **BEHAVIORAL CONCERNS**

- ☐ Avoids supervisor/coworkers
- ☐ Less communicative
- ☐ Unusually sensitive to feedback
- ☐ Unusually critical of others
- ☐ Conflict with co-workers
- ☐ Disregard for safety
- ☐ Frequent mood swings (high or low)
- ☐ Loss of interest
- ☐ Impaired judgment/memory
- ☐ Inability to concentrate

- continued -

☐

VIOLENCE ISSUES

- ☐ Threatened/intimidated others at work
- ☐ Domestic violence
- ☐ Harassment

*Please attach additional comments and/or supporting documentation
for any of the above concerns.*

SUPERVISOR PERFORMANCE GOALS

1. Have the issues marked on this form been discussed with the employee? ☐ Yes ☐ No
2. What are the consequences if employee performance does not improve?
3. Have the consequences for not improving been discussed with the employee? ☐ Yes ☐ No
4. How will the employee's improvement be measured? *(Please be as specific as possible.)*
5. How long will the employee be given to make the desired changes?

EMPLOYEE SIGNATURE

I understand that my supervisor is referring me to the Employee Assistance Program and my signature verifies that I have seen this form. My signature below does not signify my agreement or disagreement with any of the issues raised.

- ☐ Yes, I **will** participate in and cooperate with the Employee Assistance Program.
- ☐ No, I **will not** participate in the Employee Assistance Program.

Signature of employee

Date

Please forward this form by email, fax, or regular mail to:
Alan Korinek, Managing Director or Kristie Collins, Associate Director
alan.korinek@ttuhsc.edu -- kristie.collins@ttuhsc.edu
The Counseling Center at TTUHSC
Texas Tech University Health Sciences Center
3601 4th Street – STOP 8119
Lubbock, TX 79430-8119
Phone: 806.743.1327 or 1.800.327.0328
Fax: 806.743.7301
