YOUR PERMISSION PLEASE!!!

We need to know the best way to reach you to remind you of your scheduled EAP appointment. We may also need to contact you if your appointment needs to be rescheduled for any reason.

The best way to contact me is by:

- ☐ Cell Phone _____
- ☐ Home Phone _____
- ☐ Work Phone _____

☐ It is okay to leave a reminder message of my appointment time & date. **If someone else answers the phone**, it's okay to leave the reminder message with _____ Relationship: _____

☐ Do **not** call me for appointment reminders - only for emergencies please.

☐ Do **not** call me for <u>any reason</u>.

NOTE: If you choose to not be contacted for any reason by our EAP office, we will be unable to notify you in advance of any changes related to your scheduled EAP appointment. We apologize for any inconvenience this may cause.

Printed Name: _____

Signature: _____ Date: _____

Signing this form does not guarantee you will be called as a reminder. It does, however, give us permission to contact you. If at any time you change your mind, please let your counselor or the schedulers know. THANK YOU!

UnityPoint Health
Allen Hospital

Allen Employee Assistance Program
(EAP)
1825 Logan Avenue
Waterloo, IA 50703-1999
319-235-3550

EMPLOYEE ASSISTANCE PROGRAM
STATEMENT OF UNDERSTANDING

PROGRAM ELIGIBILITY AND COSTS

Allen Hospital Employee Assistance Program offers CONFIDENTIAL assessment, short-term counseling and referral, if necessary. EAP services are provided by your employer at no cost to you, the employee, your spouse, or your dependent.

Referrals to service providers outside of the EAP may be recommended to help you resolve your issues. These services may be covered under a medical benefit plan offered by your employer, insurer or HMO. However, it is your responsibility to determine whether or not these referral services are covered under any such plan and to pay any charges not covered.

CONFIDENTIALITY:

All EAP information regarding clients is kept strictly **CONFIDENTIAL.**

1. The EAP client's employer and/or family members will not know that they have used EAP services unless written permission is provided by the client to disclose this information to them.
2. No EAP client information will be released unless the EAP client signs a release of information form. If a release of information form is signed, the EAP client will be informed of the specific information to be released.
3. EAP clients who are Supervisor Referrals will sign a release of information to the referring employer for the EAP counselor to disclose appointment times/dates and depending on the situation, to disclose any recommendations.
4. No EAP client information with be shared between EAP counselors when additional/different counseling services are provided (individual or couples or family sessions) unless a release of information form is signed by each client for information to be disclosed to the new counselor providing the different counseling service.
5. No identifying information re: EAP clients is disclosed when companies are billed for EAP services.
6. All EAP client records are retained in the EAP department and are not part of Allen Hospital's medical record system.
7. Legal requirements mandate the EAP staff to report: life-threatening circumstances, including danger to self or others; child abuse; and dependent adult abuse.
8. In the event of counseling over the telephone or tele-health, it is the responsibility of the client to create a confidential environment on their end of the phone or tele-health conversation as well as establish a secure phone line or internet connection.
9. The tele-health counseling electronic systems used by Allen Hospital will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

If a client is a minor child: I give permission for my minor child to receive EAP services from the Employee Assistance Program. I certify that I am the legal parent/guardian of the minor child with the legal authority to give such permission. I authorize the following person(s) to participate in the assessment, counseling and treatment planning of my minor child:

_____ _____

I have read, understand, and agree to the conditions described in this form.

_____ _____
Signature of Client or Legal Guardian for Date

_____ _____
PRINT Client's Name Witness

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EAP CLIENT INTAKE FORM

Today's Date _____ **DOB**: _____

Client Name_____
Address _____
Street City State Zip Code
Phone: (Home):_____ (Work): _____ (Cell): _____

May we contact you at home? ☐ Yes ☐ No **May we contact you at work?** ☐ Yes ☐ No

How did you learn about EAP?

☐ Company Media ☐ EAP Media ☐ Co-worker ☐ Family ☐ Friend ☐ Other

Who referred you to EAP?

☐ Self ☐ Company ☐ Family ☐ Medical ☐ Peer ☐ Co-worker ☐ Supervisor ☐ Other

My EAP benefit is through: ☐ My company/employer ☐ My spouse/family member's company

Company Name _____

Your Work Information:

Employer: _____

Occupation: _____

Length of Employment: _____ Work Status: ☐ FT ☐ PT

Job Satisfaction: ☐ Satisfied ☐ Unsatisfied ☐ Neutral

Do you feel your presenting issue affects your job performance? ☐ Yes ☐ No ☐ Not sure

What is your primary insurance company: _____

Family Information:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Cohabitating ☐ Separated ☐ Widowed

Spouse/Partner's name: _____ Age: _____

Children's names: _____ Age: _____

_____ Age: _____

_____ Age: _____

What is the highest level of education you have completed? _____

Medical/Mental Health Information:

How would you describe your current health? ☐ Good ☐ Fair ☐ Poor

Current doctor(s):_____

Current prescription medications, over-the-counter medications or herbal preparations (name and dosage):

_____ _____ _____

_____ _____ _____

Any known allergies? ☐ Yes ☐ No If so, please list: _____

Describe any adverse/allergic reactions: _____

_____

Medical/Mental Health Information, cont.:

Please list any significant medical diagnosis and conditions:

_____ _____ _____ _____

_____ _____ _____ _____

Have you been hospitalized for any medical, past surgeries, or mental health reason? ☐ Yes ☐ No

Diagnosis _____ Year _____ Diagnosis _____ Year _____

Diagnosis _____ Year _____ Diagnosis _____ Year _____

Diagnosis _____ Year _____ Diagnosis _____ Year _____

Check any that you are presently experiencing:

☐ Chest pains	☐ Physical pain	☐ Excessive sweating
☐ Hot flashes	☐ Confusion	☐ Fainting spells
☐ Headaches	☐ Vomiting	☐ Seizures
☐ Change in appetite	☐ Numbness	☐ Shortness of breath
☐ Fatigue	☐ Tremor/Shaking	☐ Weight loss/gain
☐ Racing thoughts	☐ Sleep disturbance	☐ Hopelessness
☐ Mood swings	☐ Irritability	☐ Crying spells
☐ Angry outbursts	☐ Concentration	☐ Thoughts of hurting self
☐ Difficulty at work	☐ Difficulty at home	☐ Difficulty at school

Are there any other health problems that you feel we should know about? ☐ Yes ☐ No

If so, please explain: _____

Alcohol use? ☐ Yes ☐ No

Drug use? ☐ Yes ☐ No

Caffeine use? ☐ Yes ☐ No

Tobacco use? ☐ Yes ☐ No

Have you ever participated in treatment for any of these? ☐ Yes ☐ No

Have you ever had marital/mental health/psychiatric counseling? ☐ Yes ☐ No

Has anyone in your family had substance abuse or mental health concerns? ☐ Yes ☐ No

Legal Information:

Do you have any legal issues currently affecting your life? ☐ Yes ☐ No

Problem Areas: (Please check areas that apply)

☐ Drug/Alcohol	☐ Financial	☐ Gambling	☐ Domestic violence
☐ Legal	☐ Stress	☐ Depression	☐ Anxiety
☐ Physical health	☐ Physical abuse	☐ Sexual abuse	☐ Verbal abuse
☐ Eating concerns	☐ Anger	☐ Emotional abuse	☐ Marital/Relationship
☐ Sexual problems	☐ Family	☐ Job/Career	☐ Sexuality

I came to the EAP today because: _____

_____

I hope to accomplish: _____

_____