BEST CARE
EMPLOYEE ASSISTANCE PROGRAM

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Date

Authorization Of Service

File #:####
Authorization #:####

Assessed Problem(s): 1 = Primary 2 = Secondary 3 = Tertiary

_____ Addiction/Abuse - Other	_____ Anger	_____ Anxiety	_____ Child/Adolescent
_____ Depression	_____ Domestic Violence	_____ Emotional/Mental Health	_____ Family
_____ Financial	_____ Grief/Loss/Bereavement	_____ Job/Career	_____ Legal
_____ Life Transitions	_____ Physical Health	_____ Marital/Relationship	_____ Stress
_____ Substance Abuse/Addiction	_____ Trauma	_____ Wellness	

Clinical Impressions: _____

_____

_____

Counseling/Treatment Plan: _____

_____

_____

Clinically Necessary Referral Type: _____ No Referral Beyond EAP

_____ Agency	_____ APRN	_____ Education/Training
_____ Financial	_____ Inpatient	_____ Legal
_____ MD	_____ Psychiatrist	_____ Psychologist
_____ SAP	_____ Self-Help	_____ Substance Use Disorder
_____ Therapy	_____ Therapy Groups	

Additional Recommendations: _____

_____

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