UR Medicine EAP Supervisory Referral Protocol (Mandated Referral)

1. Supervisor identifies employee with job performance issue and reviews with designated Human Resources (HR) Representative

2. HR Representative completes the UR Medicine EAP Supervisory Job Performance Referral Form
   ***Please note: Referral Form will be shared with employee.**

3. Supervisor – Meet with employee to discuss job performance and referral to EAP and provides the following:
   - EAP phone number to obtain an appointment (276-9110)
   - A specific time by which the employee is expected to schedule an appointment with EAP, usually 24 hours.
   - *Authorization to Release Information* Form, which is to be signed by the employee during this initial meeting. Supervisor should explain that this form only gives permission to confirm when their initial appointment is scheduled and attended.

4. HR Representative should then send the following forms to EAP via confidential fax at 475-9516:
   - Completed Supervisory Referral Form
   - Copies of written documentation of disciplinary action
   - Authorization to Release Information Form Signed by employee

5. UR Medicine EAP will notify HR Representative when the employee has scheduled their initial appointment. During the employees meetings with their EAP Clinician:
   - A signed *Release of Information* form will be obtained allowing EAP to contact HR Representative with follow-up information
   - *Job Performance Referral Follow-up* forms will be completed at routine intervals in order to keep HR Representative updated on the employee's progress

6. If an employee is referred outside of the EAP for treatment, the employee will be required to sign a *Release of Information* form. This provides consent for EAP to maintain contact with HR Representative and the treating clinician, for the purpose of monitoring employee's progress. Regarding external referrals, responsibilities are as follows:
   - **URMC EAP's Responsibility:** To continue to administer *Job Performance Referral Follow-up* forms to indicate to the employer whether compliance is continuing.
   - **Employer's Responsibility:** To monitor job performance and provide updates to the EAP Counselor with respect to the employee's progress.
     ***Note: Support is available to supervisors through EAP to address worksite behaviors.**

7. The Supervisory Job Performance Referral will terminate when UR Medicine EAP Counselor, in conjunction with HR Representative, determine that the client/employee has successfully completed the treatment plan, or has refused or failed to comply with the initial appointment and/or treatment recommendations.

UR Medicine EAP Supervisory Job Performance Referral Form (Mandated Referral)

This form is to be completed by the employee's supervisor initiating the mandated referral to UR Medicine EAP. Once complete, this form is to be given to the HR Representative with copies of written documentation related to any disciplinary action taken. The HR Representative will contact EAP to initiate the referral by sending the paperwork to UR Medicine EAP via fax at 475-9516. The information gathered in the form below is intended to serve as a guideline for supervisors to describe the nature of the problem and what is expected from the employee and UR Medicine EAP in order to gain an effective resolution. The employee is expected to schedule their initial appointment with UR Medicine EAP.

***Please note that the information provided here will be shared with the employee.**

Date: _____

Organization: _____

Employee Name: _____

Referring Supervisor: _____Phone: _____

Referring Supervisor Email: _____

Human Resources Rep.: _____Phone: _____

Human Resources Rep. Email: _____

Secure Fax Number: _____

Email: _____*(Email correspondence will be sent via secure email)*

Has Employee Violated a DOT Drug & Alcohol Program Regulation? ☐ Yes ☐ No

Date Employee Was Asked to Schedule Appointment By: _____

Consequences If Appointment Is Not Made and Attended By Date Above:

Describe the job performance issue(s) that prompted mandated referral to UR Medicine EAP: (what happened, problem behaviors, duration of problem)

Describe job performance prior to issue(s) noted above:

Describe any disciplinary action(s) that have taken place regarding referral issue(s) (verbal/written warning, suspension, etc.) Please attach copies of documentation regarding disciplinary action taken.

Name(s) of the people involved in this disciplinary process:

Describe what expectations for the employee's involvement with UR Medicine EAP:

Describe what will happen if the employee chooses not to meet with the EAP or declines to follow through with UR Medicine EAP recommendations:

Document *when*, *in what form* and *by whom* the consequences for problem behaviors and/or mandated referral follow through have been clearly explained to the employee:

Thank you for completing this documentation. It is essential for the supervisory referral process to be clear for all involved and will aid toward effective resolution. If there are any questions regarding this process, you may contact UR Medicine EAP at (585) 276-9110.

UNIVERSITY *of*
ROCHESTER
MEDICAL CENTER
MEDICINE *of* THE HIGHEST ORDER

Employee Assistance Program
496 White Spruce Blvd
Box 278991
Rochester NY 14623
585-276-9110
toll free 888-764-3456
fax 585-475-9516

Authorization for Release of Behavioral Health Information

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
Employee ID#: _____ Patient's phone #: ( ) _____
Date of Request: _____ **Date Needed:** _____

X I authorize Strong Health/URMC **to release information to**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____ /
Phone #/Fax # (include area code)

OR

☐ I authorize Strong Health/URMC **to obtain information from**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____ /
Phone #/Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one) ☐ Healthcare ☐ Insurance coverage ☐ Personal **X** Other See below

TYPE OF RECORDS REQUESTED:

☐ Inpatient: date(s)_____ ☐ Outpatient: date(s)_____

☐ Specific information (Select one or more, as applicable)
- ☐ Psychiatric Evaluation and/or Treatment
- ☐ Chemical Dependency Evaluation and/or Treatment
- ☐ Laboratory test results
- ☐ Discharge Summary
- **X** Other: **Confirmation of appointment with EAP scheduled and attended.**

☐ Treatment summary (includes history/physical, laboratory tests & x-ray reports)
☐ Entire copy of the inpatient/outpatient record checked above.

AUTHORIZATION VALID FOR: (Check one)
X This request only.
☐ One year from the date of this authorization **OR** _____ (insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.
☐ This request **and** for medical records of any **future** treatment of the type described above until: _____ (insert date).

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed; except that records protected by Federal Confidentiality Rules 42CFR, Part 2 may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative _____ Date _____

Relationship to Patient *(if requester is not the patient)* _____