



CARE'S WORKLIFE SOLUTIONS SUPERVISORY REFERRAL FORM

This form **MUST** be completed and submitted to CARE's WLS in order for employee information to be disclosed to the company.
Employees presenting to CARE's WLS without this form will be processed as self-referrals.

Today's Date: _____ Company Name: _____

Name of Referring Person or Persons* : _____

Phone: _____ Fax: _____

Address: _____

****Referring person MUST be the primary or secondary contact the company has previously identified as liaison for employee assistance. CARE's WLS will only release information to this person.***

Type of feedback desired:

- Confirmation of assessment at CARE's WLS Attendance and progress
 Confirmation of admission to services/treatment Discharge status

Employee's Name: _____ Employee's Job Title: _____

Reason for Referral: Please identify all documentable job performance issues.

- Absenteeism/tardiness Disruption of workplace Decline in performance
 Failed alcohol/drug screen Failed DOT drug test

Date: _____ Substance: _____ Date: _____ Substance: _____

Other _____

Is a signed release of information attached? Yes No

Please include any additional information, such as last chance agreement, that may be helpful in assessing the situation. Please note that all information provided becomes part of the legal record and may be shared with the client.

Submit completed form to CARE's WLS by fax: 586-541-2274

Signature of primary or secondary contact person