MYgroup
McLAUGHLIN YOUNG

Employee Formal Referral Form

Supervisor & Employee Information

Employer:		Referral Date:	
Employee Name:		Employee Phone:	
Supervisor Name:		Supervisor Title:	
Supervisor Phone:		Confidential Voicemail?	☐ Yes ☐ No
Supervisor Email:		Department (if applicable):	

Reason for Referral: Please attach additional comments and/or supporting documentation

Job Performance Problems

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

Attendance Issues

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

Substance Abuse Problems

- ☐ Failed **drug** test
- ☐ Failed **alcohol** test
- ☐ Is the employee in a safety sensitive position?
- ☐ Post-accident failed drug or alcohol test
- ☐ Under the influence at work
- ☐ CDL holder/DOT violation
- ☐ Meets criteria for reasonable suspicion (Refer to EAP website for criteria)

Behavioral Concerns

- ☐ Avoids supervisors/co-workers
- ☐ 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

Violence Issues

- ☐ Threatened/intimidated others at work (may require threat assessment meeting)
- ☐ Domestic violence
- ☐ Harassment

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Performance Goals

Have the issues indicated on this form been discussed with the employee?	☐ Yes	☐ No
What are the consequences if this employee's performance does not improve?		
Have the consequences for not improving been discussed with the employee?	☐ Yes	☐ No
How will the employee's improvement be measured?		
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. 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 and cooperate with the Employee Assistance Program.		
Employee Signature:	SIGN HERE	Date:	

Please email this completed form to: formalreferral@mygroup.hush.com

If you prefer to fax, please send to 704.529.5917 to the Attn: Formal Referral Coordinator

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Authorization of Release of Client Records

Client Name:	Date of Birth:
I request and authorize McLaughlin Young Employee Services (MYgroup) to:	
☑ Release the following information to:	☑ Receive the following information from:
Name of Facility/Person:	
Address:	
Phone:	Email:

Release is for the purpose of:

- ☐ Continued care by the other provider
- ☐ Attorney
- ☐ Disability
- ☑ Formal referral
- ☐ Personal review
- ☐ Other (please specify):

Information to be disclosed if requested:

- ☑ Service dates
- ☐ Session constellation
- ☐ Session participants
- ☐ Clinical assessments
- ☑ Summary of treatment
- ☐ Other (please specify):

I understand that the information I am authorizing to be released may include mental health information and any therapy constellation (individual, couple, family, group) in which I have participated.

I further understand that this Authorization is voluntary, and I may refuse to sign this Authorization. I further understand that my treatment will not be affected if I do not sign this form (45 CFR 164.508(c)(2)).

I further understand that I may revoke this Authorization at any time by notifying MYgroup (or the releasing facility) in writing by certified mail, return receipt requested to the CEO of MYgroup, except to the extent that actions has been taken in reliance on it. Any such revocation shall not be effective until the next business day following receipt of the revocation notice by MYgroup. Unless earlier revoked, this Authorization automatically expires one year from the day signed or one year after the last MYgroup visit (45 CFR 164.508(c)(2)).

I further understand that if I refuse to authorize the release of information in a situation where the information is needed by the Employer for legal or other reasons of business necessity, it may limit MYgroup's ability to continue to provide services in which case MYgroup may make a referral to another healthcare provider. Any person or other entity who receives information pursuant to this authorization should not redisclose this information to anyone else.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

Release from Liability: I release and agree to hold harmless MYgroup (or other releasing facility) and its agents, representatives, and employees from any and all liability association with the release of confidential client information in accord with this Authorization. I understand that MYgroup (or the releasing facility) cannot be responsible for use or redisclosure of information to third parties (45 CFR 164.508(c)(2)).

To the Receiving Party of this Information: This information has been disclosed to you for the sole purpose(s) stated in this Authorization. Any other use of this information without the express written consent of the client is prohibited. These records may be protected by federal regulation (42 CFR Part 2).

I certify that this was fully explained to me; I have read it or had it read to me;* and I understand its contents.

Print Client Name/Legally Authorized Person:	Signature: SIGN HERE	Date:
Print Witness/Translator* Name:	Signature: WITNESS	Date:

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Dear Employee,

You will need to contact your Employee Assistance Program, MYgroup, at 800.633.3353, and let them know you have been formally referred by your supervisor. Please read this letter carefully and keep it for future reference.

The clinician at MYgroup will:

1. Explain your rights to confidentiality.
2. Inform you that only two pieces of information (attendance and compliance) will be shared with the specified person and everything else will remain confidential.
3. Refer you to a clinician in your area who will meet with you and assess your situation.

The clinician in your area will meet with you more than once to thoroughly assess your situation or progress. These sessions will be confidential, and there will be no cost to you for your Employee Assistance Program visits.

The treatment recommendations the clinician makes must be followed. The recommended plan of action may exceed the services covered by the Employee Assistance Program and could mean some out-of-pocket expense for you. In many cases, your health insurance will pay for treatment.

Please call us with any questions or concerns you may have. We are here to assist you.

Sincerely,

Formal Referral Coordinator
MYgroup