

Complete the Clinical Assessment during first EAP session with an Optima Client. The completed Assessment is to be filed in the client's record.

Client Name _____ Session Date _____

DOB _____ Gender Male Female

Presenting Issue

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Job/Career | <input type="checkbox"/> Marital/Relationship | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Personal Stress |
| <input type="checkbox"/> Substance Use | <input type="checkbox"/> Child/Family | <input type="checkbox"/> Health Problem | <input type="checkbox"/> Financial Issues |
| <input type="checkbox"/> Legal Issues | <input type="checkbox"/> Childcare Problem | <input type="checkbox"/> Eldercare Problem | <input type="checkbox"/> Other _____ |

Psychological/Emotional Symptoms and Brief Mental Status

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Loss of Pleasure | <input type="checkbox"/> Appetite Disturbance |
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Low Energy | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Obsessions/Compulsions |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Elated/Euphoric Mood | <input type="checkbox"/> Agitation | <input type="checkbox"/> Phobias |

Thought Process

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Oriented x 3 | <input type="checkbox"/> Impaired Memory | <input type="checkbox"/> Impaired Judgment | <input type="checkbox"/> Disorganized Speech |
|---------------------------------------|--|--|--|

Other Cognitive Impairments

- | | | | |
|--|--|------------------------------------|---|
| <input type="checkbox"/> Aggressive Behavior | <input type="checkbox"/> Conduct Problem | <input type="checkbox"/> Delusions | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Oppositional Behavior | <input type="checkbox"/> Other _____ | | |

Risk Assessment

- | Severity | Suicide Risk | Homicidal Risk | Abuse to Minor/
Vulnerable Adult | Domestic Violence |
|----------|-----------------------------------|-----------------------------------|-------------------------------------|--|
| 0 | <input type="checkbox"/> None | <input type="checkbox"/> None | <input type="checkbox"/> None | <input type="checkbox"/> None |
| 1 | <input type="checkbox"/> Ideation | <input type="checkbox"/> Ideation | <input type="checkbox"/> Ideation | <input type="checkbox"/> Verbal Abuse |
| 2 | <input type="checkbox"/> Intent | <input type="checkbox"/> Intent | <input type="checkbox"/> Intent | <input type="checkbox"/> Emotional Abuse |
| 3 | <input type="checkbox"/> Plan | <input type="checkbox"/> Plan | <input type="checkbox"/> Plan | <input type="checkbox"/> Physical/Sexual Abuse |
| 4 | <input type="checkbox"/> Means* | <input type="checkbox"/> Means* | <input type="checkbox"/> Means* | <input type="checkbox"/> Medical Care/ER Visit |
| 5 | <input type="checkbox"/> Attempt | <input type="checkbox"/> Attempt | <input type="checkbox"/> Attempt | <input type="checkbox"/> Life-Threatening |

*Includes client's access to guns

Threat of Violence Level (Levels 3 – 5 require the consideration of taking protective steps to ensure client safety. Please note if a report has been filed and any additional steps taken by the counselor.)

- | | |
|--|--|
| <input type="checkbox"/> 1 – Assessed; no indication | <input type="checkbox"/> 4 – Active threat of violence exists |
| <input type="checkbox"/> 2 – Possible threat mentioned; no current danger | <input type="checkbox"/> 5 – Client is dangerous to self and/or others |
| <input type="checkbox"/> 3 – Threat made; possibility of violent action exists | |

Comments

Optima EAP

Assessment Page 2

Client Name _____

History of Substance Use Treatment

Denies Treatment Stopped on own 12 Step/Self help Outpatient Detox Inpatient

Current duration of sobriety _____

Brief description of presenting issues

Assess the impact of presenting issue(s) on work situation

List current living situation and significant family concerns

List client strengths and support system

Provisional Clinical Evaluation (DSM –IV Code – V codes accepted)

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Initial Assistance Plan (Include one or more goals for EAP sessions. If client needs a referral state, reason and to whom referral is to be made.)

Assessors Signature _____

Credentials _____

Date _____

You have chosen to receive Employee Assistance Services through Optima EAP. These services may include assessment; brief-solution based counseling and possible referral for long-term counseling.

EAP Services are offered at no cost to employees and dependents. Your employer has already paid for these services. However, if you need long-term counseling or a specialized service, the EAP will assist you in locating a resource or service in the community. *It is your responsibility to pay for services provided by outside resources.* (Your benefit plan may cover some or all of the cost of the service. You may wish to check with your benefits representative before services are provided by a community resource.)

Your sessions with an EAP Counselor are confidential. Optima EAP will maintain confidential records of your contact with the EAP and the services you receive in order to provide continuity and coordination of your care. No information concerning your participation in Optima EAP will be discussed or released without your written consent documented on a release of information form. The following exceptions are noted:

- ◆ The Optima EAP Counselor believes that you might harm yourself or someone else. This may include information indicating impairment severe enough to pose a life-threatening situation in the workplace.
- ◆ The Optima EAP Counselor believes that a child, an elderly person or a disabled person is being abused and/or neglected.
- ◆ A court order is issued requiring the EAP to provide information in connection with certain legal proceedings such as child custody, care and protection cases, adoption proceedings, or a case against an EAP Counselor.
- ◆ If your employer has formally referred you for EAP services, the EAP is expected to confidentially inform the referral source **as to your participation in Optima EAP and your cooperation with the EAP service plan. Some employers require additional information, especially in cases related to referral based on substance use.** To permit the EAP to provide any information to your employer, you will need to sign a release of information form permitting the disclosure of that information. Only your participation, cooperation and other required information will be released. Your personal problems will not be discussed with the referral source unless you request, in writing, that this be done.
- ◆ The EAP Counselor will disclose information and records to Optima EAP as required for coordination of EAP services, quality assurance and/or payment for services provided to you.

I have read the Optima EAP Statement of Understanding including the confidentiality of the EAP and the limitations to confidentiality. Any questions about this Statement have been answered, and I understand its contents and accept it as the terms of my participation in EAP.

I release and agree to hold harmless Sentara Healthcare, Optima Behavioral Health Services, Optima EAP and their staff, employees and agents from any action or liability arising out of my participation in Optima EAP.

Signature of Client

Date

Signature of parent or guardian if client is a minor

Date

Signature of Witness

Date

Client Name _____

Name of Provider _____

In the event that our clients need long term counseling, mental health treatment, or therapy, we prefer that the EAP Affiliate Provider refer to other professionals or services covered by the client's insurance or available in the community. We recognize, however, that at times, other resources may not be available or our clients may prefer to continue service with the Optima EAP Affiliate Provider.

Optima EAP allows its EAP Affiliate Providers to refer to themselves, or "self-refer". However, to protect our clients from a potential conflict of interest, we require this "Treatment Waiver Form" is provided, explained and signed by our clients requesting services beyond EAP.

The EAP industry does not encourage self-referrals as a counselor could recommend additional therapy as a way of generating business for themselves or their practice. To ensure that the client is empowered with choices, Optima EAP requires in all self-referral situations, the EAP Affiliate Provider offer two additional referrals other than themselves or any other person, or organization where they may have financial interest, before asking the client to sign off. Please list providers below.

Referral: _____ Phone Number: _____

Referral: _____ Phone Number: _____

I _____ am requesting to continue counseling beyond my EAP benefit with _____. I understand that Optima EAP requires its EAP Affiliate Providers to provide at least two additional referrals to other clinicians or services for which they have no financial interest, as that type of situation may pose a conflict of interest for me. I understand that I am not obligated to use any of these resources or continue seeing the EAP Affiliate Provider. I understand that I will be responsible to determine if a provider and/or a particular service are covered by my health insurance benefit plan. I understand that I will be responsible for all services rendered beyond the scope of my EAP benefit.

Client Signature

Date

Submit this form to Optima EAP when the case is closed.

Client's Name: _____ Date of Final Session: _____

- | | |
|--|--|
| <input type="checkbox"/> No Show on Initial Appointment, Case Closed | <input type="checkbox"/> Involuntary (Was Fired) |
| <input type="checkbox"/> No Contact for 90 Days | <input type="checkbox"/> Voluntary (Quit Job) |
| <input type="checkbox"/> Referred Out | <input type="checkbox"/> Contract Ended |
| <input type="checkbox"/> EAP Benefit Ended | <input type="checkbox"/> Termination (Clinical) |
| | <input type="checkbox"/> EAP Counseling Complete |

Case Disposition: (Goals/Accomplishments/Progress) _____

Current Client Condition:

- Resolved Improved Returned to Work No Change Functioning Decreased

Client Referred To:

- | | | |
|---|--|---|
| <input type="checkbox"/> PCP/Physician | <input type="checkbox"/> Human Resources Department | <input type="checkbox"/> Public Agency |
| <input type="checkbox"/> Other Agencies | <input type="checkbox"/> Legal External | <input type="checkbox"/> Financial External |
| <input type="checkbox"/> Self Help Group | <input type="checkbox"/> Individual Mental Health Counseling | <input type="checkbox"/> Family/Couple Counseling |
| <input type="checkbox"/> Community Resource | <input type="checkbox"/> Client self-pay, community resource | |

Referral: _____ Phone Number _____

Referral: _____ Phone Number _____

Provider Name _____

Optima EAP

Bayside Medical Plaza • 816 Independence Blvd, Suite 3B • Virginia Beach, VA 23455

Phone 1-800-899-8174 • Fax 1-866-474-4342



Optima EAP Client Satisfaction Survey

Please take a moment to provide us feedback regarding your experience with Optima EAP.

Date _____ Company Providing Your EAP Benefit _____

Your Counselor's Name _____

Please Check The Box That Applies	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. It was easy for me to access Optima EAP by telephone.					
2. The Optima EAP office staff was friendly, helpful and courteous.					
3. I was satisfied with the length of time it took for me to get an appointment.					
4. I was satisfied with the office location for my appointment.					
5. I think my counselor listened to me and understood my concern/problem.					
6. My counselor involved me in making decisions about ways to resolve my concern/problem.					
7. I believe that my counselor has helped me resolve my concern/problem - or will be able to with additional sessions.					
8. Optima EAP is a useful and helpful resource.					
9. Overall, I am satisfied with the services provided by Optima EAP.					
<i>If you have visited our web site, we'd like to know what you think.</i> 10. The Optima EAP web site contains useful and relevant information and articles.					
Comments and/or Suggestions:					