STATE of ALABAMA ▪ EMPLOYEE ASSISTANCE PROGRAM

SUPERVISOR'S REFERRAL FORM

The following information must be completed before making the referral to BHS:

1. Before making the referral, call BHS at 800-245-1150 and speak with the State of Alabama BHS Care Coordinator.
2. Ensure that this form is filled out completely (do not leave any portion blank).
3. Confirm that this form has been signed by the employee and the referring Supervisor.
4. Attach the following to this form: the employee's job description and all documents supporting the reason for this referral

I. Employee Information (All Fields Required):

Employee _____ Position/Title _____

Cell (____) _____ Home (____) _____ Work (____) _____

State Agency/Division _____ Job Code _____

Employee Social Security # _____ Employee Date of Birth _____

II. Primary and Secondary Supervisors that will serve as primary contact with BHS in this case are:

	Name	Phone	Fax	Email
1)				
2)				

III. Current Observation(s) (check all reasons for this referral):

- ☐ * Declining job performance
- ☐ * Difficulty communicating and interacting with others
- ☐ Safety or mental health concern
- ☐ Substance abuse issue or positive drug screen

*Items with an asterisk **(*) require** a narrative description in section V of any administrative action taken prior to this referral.*

IV. Describe the behaviors or reasons for this referral (attach additional sheets if necessary):

V. Describe all previous remedial action(s) taken by the supervisor (attach additional sheets if necessary):

Acknowledgement

As the employee named on page one of this form, I understand the following:

- The information contained in and attached to this document is confidential and has been compiled to assist me.
- By signing this form, I give permission for Behavioral Health Systems, Inc. to release information to and/or receive information from the Supervisor(s) named on page one of this form, the Program Manager (SEICTF), the Employee Assistance Program Coordinator, the mental health professional conducting the assessment and

  _____.

  (list any other person[s] who should release or receive information)
- I have **FIVE (5)** business days to contact BHS at 800-245-1150 to schedule an appointment.
- If I fail to call BHS within the allotted time or attend my first scheduled appointment, BHS will inform the Supervisor(s) named on page one of this form and/or the Program Manager (SEICTF) and the Employee Assistance Program Coordinator.

Employee's Signature _____ Date _____

Supervisor's Signature _____ Date _____

The referring supervisor must complete the following BEFORE faxing this form:

- ☐ Before making the referral, call BHS at 800-245-1150 and speak with the State of Alabama BHS Care Coordinator.
- ☐ Ensure that this form is filled out completely (do not leave any portion blank).
- ☐ Confirm that this form has been signed by the employee and the Supervisor.
- ☐ Attach the following to this form: the employee's job description and all documents supporting the reason for this referral.

Fax completed form to BHS at: 205-879-1178