



Bayside Medical Plaza
 816 Independence Blvd, Suite 1A
 Virginia Beach, VA 23455
 Phone 1-800-899-8174
 Fax 1-866-474-4342

Date		# of Pages	
Attention		Fax Number	

Authorization for Optima EAP Services – Formal Referral

Client Name			
EAP Client ID #		EAP Authorization #	
# of Sessions		Authorized Dates	

Paperwork and Instructions

- Clinical Assessment Form → File in client chart
- Statement of Understanding → → File in client chart
- Client PHQ-9 Assessment → File in client chart
- Client Satisfaction Survey → Send to EAP following initial session
- Treatment Waiver Form → If applicable, send to EAP following final session
- Case Closure Form → Mail to EAP with the final claim
- Formal Referral Report → Fax to EAP within 3 days of the initial session
- Consent to Release → File in client chart

- Mail claims within 365 days of the provided service to the EAP address listed above.
- Reference the EAP Client ID # listed above. Do not bill services under the client's Health Insurance. EAP services require no co-pay.
- Mail the Case Closure Form with the final EAP claim.
- If your assessment determines the client's needs are beyond the scope of EAP, please contact us at 1-800-899-8174 for additional information.

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 |

PHQ – 9 Score _____

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

- 0
- 1
- 2
- 3
- 4
- 5

Suicide Risk

- None
- Ideation
- Intent
- Plan
- Means*
- Attempt

Homicidal Risk

- None
- Ideation
- Intent
- Plan
- Means*
- Attempt

**Abuse to Minor/
Vulnerable Adult**

- None
- Ideation
- Intent
- Plan
- Means*
- Attempt

Domestic Violence

- None
- Verbal Abuse
- Emotional Abuse
- Physical/Sexual Abuse
- Medical Care/ER Visit
- 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 _____



Statement of Understanding

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 _____

Date _____

Circle the appropriate response for each question and total your score at the bottom.

Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Occasionally	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep or staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or that you have let yourself down or your family down	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Add the total score for each column				

Total Score _____

10. If you have checked *any* of these problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	_____
Somewhat difficult	_____
Very Difficult	_____
Extremely Difficult	_____

For initial diagnosis:

Patient completes PHQ-9 Quick Depression Assessment.

- Consider a depressive disorder if there are at least 4 √s (including Questions #1 and #2). Add score to determine severity.
- Consider Major Depressive Disorder if there are at least 5 √s (one of which corresponds to Question #1 or #2)
- Consider Other Depressive Disorder if there are 2-4 √s (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (e.g. every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up √s by column. For every √: "Several days" = 1 "More than half the days" = 2 "Nearly every day" = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD	
FOR SEVERITY DETERMINATION	
For health professional use only	
Scoring—add up all checked boxes on PHQ-9	
For every √: Not at all = 0; Several days = 1;	
More than half the days = 2; Nearly every day = 3	
Interpretation of Total Score	
Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Your feedback is important to Optima EAP, so we ask that you please take a moment to complete this survey regarding your experience. Do not include your name. Thank you.

Date _____ Company Providing the EAP Benefit _____

Provider Name _____

	Yes	No
1. It was easy for me to access Optima EAP by telephone.	Yes	No
2. I was satisfied with the level of customer service provided by the Optima EAP office staff.	Yes	No
3. I was satisfied with the length of time it took for me to get an appointment.	Yes	No
4. I was satisfied with the office location for my appointment.	Yes	No
5. I believe that the counselor listened to me and understands my concern or situation.	Yes	No
6. I believe that the counselor is helping me address my concern or situation.	Yes	No
7. I understand the suggestions made by my counselor.	Yes	No
8. I appreciate that my company makes Optima EAP available.	Yes	No
9. I believe Optima EAP is a useful and helpful resource.	Yes	No
10. Overall, I am satisfied with the quality of the services provided by Optima EAP.	Yes	No

Comments

Optima EAP

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Phone 757-363-6777 or 1-800-899-8174 • Fax 757-363-6778 or 1-866-474-4342

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

Complete the case closure form when the case is closed and send or fax to Optima EAP.

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 _____

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Case Information

Client Name: _____ DOB _____

Client's Employer: _____

Report

Client has signed Release of Information Form permitting communication between EAP/Provider and EAP/Referring Manager. yes no

Client attended scheduled appointment(s) yes no

List Appointment date(s) _____

Does the Client have another appointment scheduled? yes no

If yes, when? _____

Client agreed to a plan of action related to behaviors that led to the formal referral. yes no

Client is making progress in changing the behaviors that led to the formal referral. yes no

Clinician's Signature

Date

Print Clinician's Name

Clinician's preferred phone number

Please fax this form to Optima EAP within three business days of the client's initial appointment.

**Attn: Optima EAP Case Manager
757-363-6778 or 1-866-474-4342**



Consent To Release of Protected Health Information

Client Name: _____

Date of Birth: _____

This release is to allow the communication required by the EAP Formal Referral Process. I authorize the following communication:

Mike Powell, Optima EAP Case Manager or designate with _____, EAP Affiliate Provider and,

Mike Powell, Optima EAP Case Manager or designate with _____, referring supervisor/manager.

Specific information to be disclosed: 1) Information related to workplace behaviors that led to the formal referral, 2) Information regarding attendance at all EAP counseling sessions, 3) Compliance with the treatment plan, 4) Other _____

Purpose of request (required only if records concern Alcohol and/or Substance Abuse): _____

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of protected health care records and information. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records or receiving information. Furthermore, I understand that my consent may not be revoked to the extent that the provider, person, or program authorized to make the disclosure has already taken action in reliance on my consent. A copy of this consent and notation concerning the persons or agencies to whom disclosure was made shall be included with my original records.

I understand that if I am referred to a mental health provider, I am responsible for any deductibles, co-payments, and/or fees charged.

I understand that no legal responsibility or liability of any nature will attach to Optima Employee Assistance Program or any employee in acting on this authorization request.

This consent expires on the following date, event, or condition: _____

Signature of Patient _____ Date _____

Witness _____

PROHIBITIONS ON REDISCLOSURE:

1. The person who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless recipient is a provider who makes a disclosure permitted by law.
2. Any Alcohol and Drug Abuse information, which has been disclosed to you from records, confidentiality is protected by Federal confidentiality rules (42.C.F.R part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the patient. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
3. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I may contact Optima Privacy Officer at (757) 857-8494 or by mail to Optima HIPAA Privacy Contact Person, P.O. Box 2200, Norfolk, VA 23501.