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

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

- 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.

~ As always, thank you for your services. ~

Optima Health

Optima EAP Clinical Assessment Form

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

☐ Job/Career	☐ Marital/Relationship	☐ Mental Health	☐ Personal Stress
☐ Substance Use	☐ Child/Family	☐ Health Problem	☐ Financial Issues
☐ Legal Issues	☐ Childcare Problem	☐ Eldercare Problem	☐ Other _______________

Psychological/Emotional Symptoms and Brief Mental Status

☐ Anxiety	☐ Depressed Mood	☐ Loss of Pleasure	☐ Appetite Disturbance
☐ Sleep Disturbance	☐ Low Energy	☐ Panic Attacks	☐ Obsessions/Compulsions
☐ Irritability	☐ Elated/Euphoric Mood	☐ Agitation	☐ Phobias

PHQ – 9 Score _________

Thought Process

☐ Oriented x 3 ☐ Impaired Memory ☐ Impaired Judgment ☐ Disorganized Speech

Other Cognitive Impairments

☐ Aggressive Behavior ☐ Conduct Problem ☐ Delusions ☐ Hallucinations

☐ Oppositional Behavior ☐ Other ____________________________

Risk Assessment

Severity	Suicide Risk	Homicidal Risk	Abuse to Minor/ Vulnerable Adult	Domestic Violence
0	☐ None	☐ None	☐ None	☐ None
1	☐ Ideation	☐ Ideation	☐ Ideation	☐ Verbal Abuse
2	☐ Intent	☐ Intent	☐ Intent	☐ Emotional Abuse
3	☐ Plan	☐ Plan	☐ Plan	☐ Physical/Sexual Abuse
4	☐ Means*	☐ Means*	☐ Means*	☐ Medical Care/ER Visit
5	☐ Attempt	☐ Attempt	☐ Attempt	☐ 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.)

☐ 1 – Assessed; no indication
☐ 2 – Possible threat mentioned; no current danger
☐ 3 – Threat made; possibility of violent action exists
☐ 4 – Active threat of violence exists
☐ 5 – Client is dangerous to self and/or others

Comments

Optima EAP

Assessment Page 2

Client Name ______________________________

History of Substance Use Treatment

☐ **Denies Treatment** ☐ **Stopped on own** ☐ **12 Step/Self help** ☐ **Outpatient** ☐ **Detect** ☐**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

Optima Health

Client PHQ-9 Assessment

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

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Client Satisfaction Survey

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 ____

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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Optima Health

Treatment Waiver Form

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

OptimaHealth

Optima EAP Case Closure Form

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

Client's Name: ________________________________ Date of Final Session: _________

☐ No Show on Initial Appointment, Case Closed
☐ No Contact for 90 Days
☐ Referred Out
☐ EAP Benefit Ended

☐ Involuntary (Was Fired)
☐ Voluntary (Quit Job)
☐ Contract Ended
☐ Termination (Clinical)
☐ EAP Counseling Complete

Case Disposition: (Goals/Accomplishments/Progress)________________________________
____
____
____

Current Client Condition:

☐ Resolved ☐ Improved ☐ Returned to Work ☐ No Change ☐ Functioning Decreased

Client Referred To:

☐ PCP/Physician
☐ Other Agencies
☐ Self Help Group
☐ Community Resource

☐ Human Resources Department
☐ Legal External
☐ Individual Mental Health Counseling
☐ Client self-pay, community resource

☐ Public Agency
☐ Financial External
☐ Family/Couple Counseling

Referral:________________________________ Phone Number ____________________

Referral: ________________________________ Phone Number ____________________

Provider Name ____

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