



PO Box 1032
York, PA 17405
Phone: 800-364-6352
Fax: 717-851-1414
www.questbh.com

Supervisory Referral Process

The supervisor should initiate the Supervisory Referral Process after it has determined an employee should be the subject of a formal supervisory referral.

- 1) The referring supervisor should complete the Supervisory Referral Informed Consent form. This form allows the supervisor an opportunity to describe the reason for the referral. The employee and supervisor sign this form in the designated spaces. If the supervisor needs additional space to describe the reason for the referral, he/she can attach an additional sheet of paper with the supporting documentation.
 - a. If additional documentation is included, the employee must sign EACH page with a statement indicating he/she is aware that this documentation will be forwarded to Quest EAP and the provider.
- 2) Communication from Quest EAP of information pertinent to the supervisory referral will be limited to the Primary and Secondary HR Contact(s) noted on the Supervisory Referral Informed Consent form.
- 3) The supervisor and/or HR staff should encourage the employee to contact Quest at 800-364-6352 to speak with a Care Manager (CM). A CM will assist the employee in locating an appointment with a Quest contracted provider. After the initial appointment is scheduled, a member of Quest's Supervisory Referral team will notify HR contact(s) of appointment date and fax the Supervisory Referral Informed Consent to the assigned provider.
- 4) After each appointment, the provider will complete an Employee Status Report form and submit to Quest. A member of Quest's Supervisory Referral team will contact the designated HR contact(s) with the status of the appointment and date of the next scheduled appointment, if applicable. This step will repeat until the employee attends all authorized EAP sessions.
 - a. At no time during the supervisory referral process will Quest staff disclose information to the referring supervisor unless he/she has also been designated as the primary or secondary HR contact on the Supervisory Referral Informed Consent form.

For additional information regarding the Supervisory Referral process, please refer to www.questbh.com/employers.

*If the information in this communication or any of its attachments is related to substance use treatment, the following statement applies:
"42 CFR Part 2 prohibits unauthorized use or disclosure of these records."*

Supervisory Referral Guidelines for Documentation

Documentation of a performance or behavioral problem should:

- 1) Include specific dates, times, and locations.
- 2) Include a detailed description of the nature of the incident or performance problem.
- 3) Cite the violated policy, procedure, or other work rule.
- 4) Note the impact of the behavior or problem on the employee's overall work performance and/or operation of the unit.
 - a. Include past response(s) of the supervisor to the incident or problem and possible disciplinary action(s).
- 5) If you need additional space for your narrative, please include an addendum signed by both the employee and referring supervisor indicating the employee's knowledge and consent to sharing information with Quest EAP and the assigned provider.

In addition to the above elements of documentation, the supervisor should also reference the following:

- 1) Record the incident or situation as soon as it occurs; this ensures the greatest degree of accuracy.
- 2) Be objective and focus solely on the job.
- 3) Do not diagnose nor speculate as to the cause of the problem.
- 4) Keep all information confidential.

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Supervisory Referral Informed Consent (Please complete both pages in full)

I hereby authorize Quest EAP to disclose information to:

Primary HR Contact Name	Contact Telephone and Fax Number	Primary HR Email Address
Secondary HR Contact Name	Contact Telephone and Fax Number	Secondary HR Email Address
For the records of:		
	Employee Full Name	Date of Birth (mm/dd/yyyy)
Street Address	City	State / Zip
Primary Contact #	Alternate Contact #	Type of Medical Insurance

Type of Referral

- ☐ **Standard:** Use of available EAP sessions with a Quest credentialed provider.
- ☐ **Return to Work Evaluation:** Brief written recommendation provided by a Quest credentialed provider. Employee must verify with provider that they are able to perform this service prior to scheduling.
- ☐ **Fitness for Duty (Additional cost):** Formal evaluation by a doctoral level licensed psychologist.
- ☐ **Department of Transportation / Substance Abuse Professional (DOT/SAP) (Additional cost):** Evaluation for operators and CDL drivers needing to return to duty.

Additional Comments (information will be released to Quest EAP provider):

Work-related issues (check all that apply):

<input type="checkbox"/> Decreased productivity	<input type="checkbox"/> Impaired judgement
<input type="checkbox"/> Erratic work pattern	<input type="checkbox"/> Inability to concentrate
<input type="checkbox"/> Excessive or unexcused absences	<input type="checkbox"/> Increased errors
<input type="checkbox"/> Failed drug/alcohol test	<input type="checkbox"/> Lower quality of work
<input type="checkbox"/> Failure to meet schedules/deadlines	<input type="checkbox"/> Physical or verbal Aggression
<input type="checkbox"/> Other (describe)	

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Information to be Released

Please have employee contact Quest within 48 hours from the date of signature.

By my signature below, I recognize that the information to be released may include my scheduled appointment dates and attendance, compliance with treatment recommendations and completion of treatment. Treatment recommendations may include but are not limited to suggestions made by the EAP regarding referral for treatment beyond EAP outpatient sessions, recommendations for follow-up drug/alcohol testing (if referral was made for substance use/abuse), and suggestions for my employer to assist me with resolving the issue(s) that prompted this referral.

This information is being disclosed to the above person, organization or agency from records whose confidentiality may be protected by the Drug and Alcohol Abuse Control Act (Pennsylvania Law, Act 63) and/or the Mental Health Procedures Act (Pennsylvania P.L. 817) and/or Confidentiality of Alcohol and Drug Abuse Patient Record Regulations (Federal Public Law 93-282) or, in accordance with the state regulations where you receive EAP services. My signature below authorizes release of all such information. I also understand and agree that the above person, organization, or agency may release additional workplace performance information to the EAP administrator and service provider to focus the Supervisory Referral treatment in the most productive manner.

I understand that I have no obligation to disclose information from my record and understand that I may revoke this authorization at any time in writing, except regarding communications that have already taken place. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated. This authorization shall expire upon completion of the EAP Supervisory Referral Process or one year from the date executed, whichever comes first, unless otherwise specified.

I understand that my employer is referring me to the Employee Assistance Program. I also understand that my signature below does not reflect my agreement/disagreement with any of the issues raised. My signature verifies that I have seen the referral and documentation contained therein and I understand this form will be forwarded to Quest EAP. I further understand that once an appointment with a provider is scheduled, Quest will send a copy of this form to that provider. I recognize that this is a voluntary process and that this is an informed consent form so that the Human Resources contact person can work cooperatively with Quest staff. I am aware that information exchanged will be directly related to work related issues and/or EAP attendance.

- ☐ YES, I will participate in the Employee Assistance Program.
- ☐ NO, I will not participate in the Employee Assistance Program.

Print Employee Name

Employee Signature

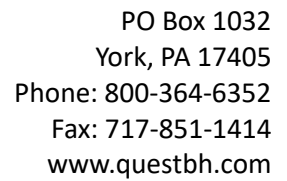
Date

Print HR Contact Name

HR Contact Signature

Date

Email completed form to QuestEAP@questbh.com or fax to 717-851-1414.



(Information will be released to Quest EAP provider)

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Date

Date

Email completed form to QuestEAP@questbh.com or fax to 717-851-1414.