



NATIONAL NETWORK PROVIDER'S REPORT

CLIENT FULL NAME: _____

PEREFRRRED EAP#: _____

PROVIDER NAME: _____

DATE OF REPORT: _____

DATES OF SERVICE: _____

ASSESSMENT INFORMATION

• IDENTIFIED PROBLEM(S): _____

• SYMPTOMS OF IDENTIFIED PROBLEM(S) (please be specific): _____

• IS THIS CLIENT AT RISK FOR SUICIDE OR HOMICIDE? IF YES, PLEASE EXPLAIN:

→ OVER

• SUBSTANCE ABUSE HISTORY: _____

• MEDICATIONS: _____

• BEHAVIORAL HEALTH TREATMENT HISTORY (IP & OP / WHEN, WHERE, DIAGNOSES):

REFERRAL & OUTCOME INFORMATION

- OUTCOME
 _____ SERVICE COMPLETED, TERMINATED BY MUTUAL AGREEMENT
 _____ SERVICE NOT COMPLETED, CLIENT DROPPED-OUT
- PROGNOSIS: _____
- WAS THE CLIENT REFERRED FOR CONTINUED CARE? ___ YES ___NO
 - IF YES, TO WHOM: _____
 - PHONE: _____
 - LINKAGE CONFIRMED? __ YES __ NO ___ UNKNOWN

ADDITIONAL COMMENTS

