

TTU SUPERVISOR REFERRAL FORM

For Mandatory Referrals To The EMPLOYEE ASSISTANCE PROGRAM

Note to the Supervisor: If this is your first time to make a mandatory referral to the EAP, please call **806-743-1327** and ask to speak to the EAP Director or Associate Director. Thank you.

SUPERVISOR AND EMPLOYEE INFORMATION

Please print

Employee's Name: _____ Referral Date: _____

Employer: _____

Department (if applicable): _____ Employee's Phone: _____

Referring Supervisor's Name: _____ Title: _____

Supervisor's Phone (work /cell): _____ Confidential Voice Mail? Yes No

Supervisor's E-Mail: _____

REASON FOR REFERRAL

Please indicate the reason(s) for this referral (*check all boxes that apply*).

JOB PERFORMANCE PROBLEMS

- Lower quality of work
- Decreased productivity
- Increased errors
- Erratic work patterns
- Failure to meet schedules

- Attendance
 - Excessive tardiness
Days late in past month: _____
 - Excessive absence
Days absent past 3 months: _____
 - Other _____

SUBSTANCE ABUSE PROBLEMS

- Failed *drug* or *alcohol* test. (*Please circle which one.*)
 - Is the employee in a safety sensitive position?** Yes No
- Post-accident failed drug or alcohol test
- Under the influence at work
- Meets criteria for "reasonable suspicion"

BEHAVIORAL CONCERNS

- Avoids supervisor/coworkers
- Less communicative
- Unusually sensitive to feedback
- Unusually critical of others
- Conflict with co-workers
- Disregard for safety
- Frequent mood swings (high or low)
- Loss of interest
- Impaired judgment/memory
- Inability to concentrate

- continued -

VIOLENCE ISSUES

- Threatened/intimidated others at work
- Domestic violence
- Harassment

*Please attach additional comments and/or supporting documentation
for any of the above concerns.*

SUPERVISOR PERFORMANCE GOALS

1. Have the issues marked on this form been discussed with the employee? Yes No
2. What are the consequences if employee performance does not improve?
3. Have the consequences for not improving been discussed with the employee? Yes No
4. How will the employee’s improvement be measured? *(Please be as specific as possible.)*
5. How long will the employee be given to make the desired changes?

EMPLOYEE SIGNATURE

I understand that my supervisor is referring me to the Employee Assistance Program and my signature verifies that I have seen this form. My signature below does not signify my agreement or disagreement with any of the issues raised.

- Yes, I **will** participate in and cooperate with the Employee Assistance Program.
- No, I **will not** participate in the Employee Assistance Program.

Signature of employee

Date

Please forward this form by email, fax, or regular mail to:
Dr. Alan Korinek, Director or Kristie Collins, Associate Director
The Counseling Center at TTUHSC
Texas Tech University Health Sciences Center
3601 4th Street – STOP 8119
Lubbock, TX 79430-8119
Email: ***counselingcenter@ttuhsc.edu***
Phone: 806.743.1327 or 1.800.327.0328
Fax: 806.743.7301
