Clinical Service Form

Client Name: _____ Client Date of Birth: _____

Case Number: _____ Provider : _____

Client Employer:

Payment Information

Tax ID or SSN: _____

Billing Address: _____

Make Check Payable To: _____

Dates of Service:

Date	Length of Session	Contracted Rate

Assessed Concerns (check all that apply)

- ☐ Alcohol
- ☐ Crisis
- ☐ Depression
- ☐ Drug
- ☐ Emotional
- ☐ Family Problems
- ☐ Risky Drinking
- ☐ Other Problem _____
- ☐ Interpersonal
- ☐ Job Related
- ☐ Marital
- ☐ Medical
- ☐ Stress
- ☐ Other's Addiction

Recommendations/Referrals Provided

- ☐ Community Resource _____
- ☐ Human Resource _____
- ☐ Sub. Abuse-Inpatient _____
- ☐ Sub. Abuse-Partial _____
- ☐ Sub. Abuse-IOP _____
- ☐ Sub. Abuse-Outpatient _____
- ☐ Sub. Abuse-Education _____
- ☐ Mental Health-Inpatient _____
- ☐ Mental Heath-Partial _____
- ☐ Mental Health-IOP _____
- ☐ Psychiatrist _____
- ☐ Self Help Group _____
- ☐ Medical _____
- ☐ Other _____
- ☐ Private Clinician-List Below
- ☐ Self Referral (please list two names given to client)

Referral #1 (Name/Phone)

Referal #2 (Name/Phone)

Outcomes: (check one)

- ☐ Completed EAP-No Referral
- ☐ Completed EAP See Referrals
- ☐ Unable to contact client. No response to calls.
- ☐ Client decision not to continue, Affiliate agrees.
- ☐ Client decision not to continue, Affiliate disagrees.
- ☐ Employment terminated.

Problem Status At Closing: (check one)

- ☐ Resolved
- ☐ Improved
- ☐ Unchanged
- ☐ Worsened

Affiliate Signature:

Date: _____

Please return by mail or fax to:

Lytle EAP Partners

200 Cedar Ridge Drive, Suite 208
Pittsburgh, PA 15205
Clinical Fax (412) 921-7261

LYTLE EAP PARTNERS
Well-being at work