



REFERRAL FORM EAP

Date of Referral: _____

Referring Agency: _____

Address: _____

Phone: _____

Fax: _____

Contact Name: _____

Client ID: _____

Client Company: _____

Authorized Sessions: _____

Patient Details:

Name: _____ Medicare No. _____

Phone: _____ Date of Birth: _____

Address: _____

Reason for Referral (please circle):

psycho education / depressive disorder / anxiety / panic attacks / OCD / schizophrenia / stress / trauma / pain / bullying / addiction / aggression / ADHD / behavioral management / school or work / intellectual disability / skill development / relationship problems / family problems / adjustment / career-related issues / supportive counseling / grief & loss / other:

Goals of therapy

assessment / diagnosis / develop treatment plan / provide recommendations and feedback / reduce symptoms develop skills / resolve issues / provide focused psychological strategies

Other: _____

Relevant Medical / Psychiatric History:

Urgency of Referral: None / Se mi-Urgent / Urgent

Suicide Risk: None / Mild / Moderate / High

Risk to Others: None / Mild / Moderate / High

Languages available Chinese / Cantonese / Greek / English