ADMINISTRATIVE REFERRAL

I. **REFERRAL INFORMATION** DATE:_____

Referral made by: _____ Title:_____

Work phone:_____ Pager: _____ Cell phone: _____

Relationship to the identified client:_____

II. IDENTIFIED CLIENT INFORMATION

_____ _____ _____ _____ _____
(First Name) (Middle Name) (Last Name) (Sex) (Age)

Address _____ Cell Phone: _____

_____ _____ _____ Work Phone:_____
(City) (State) (Zip Code)

Employee ID#: _____ Terminal Degree: _____

Occupation: _____ Division/School/Location: _____

Annual Income: ◯ 0-9,999 ◯ 10-14,999 ◯ 15-19,999 ◯ 20-24,999 ◯ 25-49,999 ◯ 50-Over Health Insurance: _____

III. BACKGROUND INFORMATION

1. Is or has any disciplinary action taken place? ◯ Yes ◯ No
2. Has the individual been reported to a professional board? ◯ Yes ◯ No
3. How would you rate the performance of this individual at this time? ◯ Outstanding ◯ Above Average ◯ Average ◯ Below Average ◯ Unacceptable
4. How many days has this individual missed during the last 3 months? ◯ None ◯ 1-5 ◯ 5-10 ◯ 11-15 ◯ 16 and over

IV. CONSENT

This section must be read by the identified client and the appropriate signatures are required below.

I _____understand I am being formally referred to the CAP and / or drug testing program. As a condition of this referral, I will need to sign a release of information which allows administration to be informed of my participation and any and all necessary information in order to comply with the conditions of this referral. My signature below indicates my permission for CAP and / or drug testing program to contact and relay such information to administration. I understand should I refuse, or withdraw this permission, my case will be closed by CAP and / or the drug testing program, and administration will be informed of my choice to not participate. This could result in administrative action up to and including termination.

CAP Drug Testing Program Appointment Date / Time: _____Location: _____

_____	_____	_____
Identified Client's Signature	Title / position	Date
_____	_____	_____
Supervisor/Faculty Member Signature	Title	Date
_____	_____	_____
Designated Authority's / Administrator Signature	Title	Date

V. SERVICES RECOMMEDNED

For Campus Assistance Program Use Only	
Services Recommended (CAP will check mark recommended service)	
☐ Fitness for Duty (documentation indicates individual may be impaired)	☐ Threat Assessment (documentation indicates individual may pose a risk)
☐ Drug Testing (Post accident/reasonable suspicion, the drug test must be performed within (8) hours of the incident)	☐ Other:

PeopleSoft account number required for post-accident/reasonable suspicion drug testing

Account	Fund	Department	Program	Class	Project

VI. REASONS FOR REFERRAL
PLEASE PLACE A CHECK IN THE SPACE NEXT TO BEHAVIOR OR SYMPTOMS OBSERVED

ATTENDANCE
☐ Excessive absenteeism
☐ Unusual excuses for absence
☐ Extended lunch periods
☐ Early departures
☐ Excessive lateness
☐ Frequently leaves work-site
☐

PERFORMANCE
☐ Lower quality of work
☐ Failure to meet deadlines
☐ Decreased productivity
☐ Impaired judgment/memory
☐ Inability to concentrate
☐ Increased errors
☐ Erratic patterns

BEHAVIOR
☐ Avoids others
☐ Loss of interest or enthusiasm
☐ Less communicative
☐ Sensitive to advise or constructive criticism
☐ Disregard for safety
☐
☐

GENERAL APPEARANCE
☐ Fighting
☐ Suspicious
☐ High
☐ Guarded
☐ Fearful
☐ Crying
☐ Angry
☐ Irritable
☐ Anxious
☐ Mood Swings
☐ Excited
☐ Depressed
☐ Sleepy
☐ Distracted
☐ Evasive
☐ Indifferent
☐ Polite
☐ Calm
☐ Cooperative
☐

GROOMING
☐ Bizarre
☐ Dirty
☐ Disheveled
☐ Sloppy
☐ Messy
☐ Unkempt
☐ Neat/acceptable

SPEECH
☐ Incoherent
☐ Slurred
☐ Slobbering
☐ Loud
☐ Rapid
☐ Slow
☐ Hesitant
☐ Soft
☐ Normal
☐ Alcohol – like odor on breath

ABILITY TO STAND
☐ Unable to stand
☐ Feet wide apart for balance
☐ Leaning for balance
☐ Rigid
☐ Sagging
☐ Swaying
☐ No problem

ABILITY TO WALK
☐ Unable to walk
☐ Falling
☐ Staggering
☐ Holding on for stability
☐ Wobbling
☐ Weaving
☐ Swaying
☐ No problem
☐
☐
☐

ORIENTATION
☐ Knows time of day
☐ Knows his / name
☐ Knows where he / she is

ACTIONS
☐ Threatening
☐ Profanity
☐ Punching
☐ Kicking

EYES
☐ Bloodshot
☐ Watery
☐ Droopy lids
☐ Glassy eyed

FACE
☐ Flushed
☐ Pale
☐ Other

VII. REASON FOR REFERRAL (Document specifics, date / location, who observed behavior / incident(s)):