INTEGRATED BEHAVIORAL HEALTH

IBH EAP CASE SUMMARY

Please complete & return to IBH with billing.
(Claims will not be processed until Case Summary is received.)

GENERAL INTAKE

EAP Counselor: | Date Case Opened:

Phone: | Fax: | EAP Group Name:

Address:

City: | State: | Zip:

Intake Service Level: (Check One Only)
☐ Crisis ☐ Urgent ☐ Priority ☐ Routine ☐ Other

Patient Name: _____

Insured's Name (if Different from Patient): _____ Insured's SS#: _____

Account (Insured's Employer or Union):

Referred to EAP By: (Check One Only)

☐ Co-Worker	☐ Union	☐ Human Resources
☐ Employer/Supervisor	☐ Medical	☐ Law Enforcement
☐ Family	☐ Self-Referred*	☐ Other

*If **Self-Referred**, List How Patient Knew about EAP: (Check One Only)

Self-Orientation:	EAP Literature:	EAP Services:
☐ New Employee Orientation	☐ Employee Manual/Benefits Literature	☐ Workshop/Seminar
	☐ Brochure	☐ Management, Union, or Employee Training
	☐ Posters/Flyers	

CLIENT DEMOGRAPHICS

Sex: ☐ Female ☐ Male | Date of Birth: | Length of Service with Employer:

Client Relationship to Insured (Employee/Union Member): (Check One Only)
☐ Self ☐ Spouse ☐ Dependent ☐ COBRA ☐ Retiree

☐ < 1yr ☐ 1-5 yrs ☐ 6-10 yrs ☐ 11-15 yrs ☐ 16-20 yrs ☐ > 20 yrs

Age:
☐ 0-10 ☐ 10-20 ☐ 20-30 ☐ 30-40
☐ 40-50 ☐ 50-60 ☐ Over 60

Marital Status:
☐ Married ☐ Remarried ☐ Separated
☐ Divorced ☐ Widowed` ☐ Never Married

JOB PERFORMANCE/ATTENDANCE PROBLEMS
(Applies only if Patient is Same as Insured)

Performance or Attendance Problems in the Last 6 months: ☐ Yes ☐ No

If Yes, Primary Reason for Performance/Attendance Problems (Check one only):

☐ Work Problem/Duties	☐ Suspension	☐ Depression	☐ Medical Problem
☐ Work Problem/Peer	☐ Drug/Alcohol Problem	☐ Sleep Disorder Problem	☐ Worker's Compensation
☐ Work Problem/Supervisor	☐ Dependent Care Problem	☐ Other Mental Health Problem	☐ Sexual Harassment
☐ Work Problem/Other			☐ Other

PROBLEM ASSESSMENT

PRIMARY PROBLEM (Check one only):

☐ Depression	☐ Violent Thoughts	☐ Friend Relational	☐ School
☐ Anxiety	☐ Alcohol Abuse	☐ Domestic Violence	☐ Vocational
☐ Eating Disorder	☐ Polysubstance Abuse	☐ Child Abuse	☐ Work Problem / Duties
☐ Sleep Problems	☐ Family Drug/Alcohol Problem	☐ Child Care	☐ Work Problem / Peer
☐ Sexual Problem	☐ Gambling Addiction	☐ Dependent Adult Care	☐ Work Problem / Supervisor
☐ Grief/Loss	☐ Marital/Life Partner Relational	☐ Elder Care	☐ Work Problem / Drug Test
☐ Behavioral Problems	☐ Significant Other Relational	☐ Financial	☐ Work Problem / Attendance
☐ High Risk Behavior	☐ Child Relational	☐ Legal	☐ Work Problem / Other
☐ Violent Behavior	☐ Parent Relational	☐ Housing	☐ Medical Complications

SECONDARY PROBLEMS (May be more than one per Client):

☐ Depression	☐ Violent Thoughts	☐ Friend Relational	☐ School
☐ Anxiety	☐ Alcohol Abuse	☐ Domestic Violence	☐ Vocational
☐ Eating Disorder	☐ Polysubstance Abuse	☐ Child Abuse	☐ Work Problem / Duties
☐ Sleep Problems	☐ Family Drug/Alcohol Problem	☐ Child Care	☐ Work Problem / Peer
☐ Sexual Problem	☐ Gambling Addiction	☐ Dependent Adult Care	☐ Work Problem / Supervisor
☐ Grief/Loss	☐ Marital/Life Partner Relational	☐ Elder Care	☐ Work Problem / Drug Test
☐ Behavioral Problems	☐ Significant Other Relational	☐ Financial	☐ Work Problem / Attendance
☐ High Risk Behavior	☐ Child Relational	☐ Legal	☐ Work Problem / Other
☐ Violent Behavior	☐ Parent Relational	☐ Housing	☐ Medical Complications

REFERRALS

REFERRAL GIVEN TO: (Check All That Apply)

Behavioral Health Services

Provider Type:
- ☐ LPC/MFCC/LCSW
- ☐ PhD
- ☐ MD
- ☐ Other

Psychiatric Programs:
- ☐ Psych Inpatient
- ☐ Psych Residential
- ☐ Psych 6-8 Hr SOP
- ☐ Psych 3-4 Hr IOP

Outpatient Behavioral Treatment:
- ☐ Group Therapy
- ☐ Marital Therapy
- ☐ Individual Therapy
- ☐ Family Therapy

Chemical Dependency Programs:
- ☐ CD Detox
- ☐ CD Inpatient
- ☐ CD Residential
- ☐ CD 8-Hr SOP
- ☐ CD 4-Hr IOP

☐ Continued EAP Services

Medical Treatment:
- ☐ Inpatient Medical Program
- ☐ Medical/Personal Physician

Community Resources:
- ☐ Child Care
- ☐ Elder Care
- ☐ Career Counseling
- ☐ Academic Counseling
- ☐ Stress Management
- ☐ Legal
- ☐ Financial
- ☐ Housing
- ☐ Social Agency
- ☐ AA or Other 12-Step
- ☐ Grief Group
- ☐ Parent Education Group
- ☐ Other Support Group

Employer/Union Resources:
- ☐ Human Resources
- ☐ Supervisor
- ☐ Employer/Union Rep

If **Behavioral Health** Treatment Referrals were made, were the Providers or Facilities within the Insured's Benefit Plan: ☐ Yes ☐ No

CASE CLOSURE SUMMARIES

Number of EAP Sessions:	Date Case Opened:	Date Case Closed:

Case Closed Due To:

☐ Resolved ☐ Declined Help ☐ Suspended ☐ Terminated ☐ Laid Off ☐ Quit Job ☐ Retired ☐ Deceased

ASSESSMENT/REFERRAL OUTCOMES

Check One of the Following:

- ☐ Improved/Resolved problem through EAP only
- ☐ Accepted referral but client failed to complete referral
- ☐ Other (left employment; unable to contact)
- ☐ Accepted referral & completed referral
- ☐ Refused EAP assistance

TREATMENT/FOLLOW-UP OUTCOMES

Check One of the Following:

- ☐ Completed major EAP recommendations
- ☐ Refused EAP assistance
- ☐ Completed some EAP recommendations
- ☐ Other (left employment; unable to contact)

INTEGRATED BEHAVIORAL HEALTH

PO Box 30018, Laguna Niguel, CA, 92607-0018 • (800) 395-1616 • Fax (714) 556-5430

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize
(please print or type client name)

EAP Provider Name: _____

Address: _____

Telephone: (_____) _____

to disclose records and information obtained in the course of EAP Services to Integrated Behavioral Health and its authorized employees.

I, _____, hereby authorize Integrated Behavioral Health
(Client Name)
and its authorized employees to provide the above named provider with information regarding my EAP benefits, and to disclose and discuss all information needed to determine the necessary and appropriate services.

I understand that I can limit my disclosure to specific types of information and have noted disclosure limitations as follows (Check and initial #1 or #2):

(Client's Initials)

1. ___ No disclosure limitations 1. _____
2. ___ Disclosure limited to the following types of information 2. _____

I understand that I can revoke this consent at any time, except to the extent that action has been taken in reliance of this consent prior to my revocation. I understand that this authorization will expire two years after the date of my signature, or, if not earlier revoked, it shall terminate on:

_____
(Event, Date, or Condition)

I also understand that I have a right to a copy of this authorization.

Client Name (Please Print): _____

_____
(Signature of Client, Parent, Guardian or Authorized Representative of Client) *Date*

_____
(If signed by other than client, indicate legally responsible relationship)

Subscriber SS #: _____

Return to: **Integrated Behavioral Health**
IBH EAP Services
P. O. Box 30018
Laguna Niguel, CA 92607-0018

HIPAA NOTICE:
THIS INFORMATION HAS BEEN DISCLOSED FROM CONFIDENTIAL RECORDS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CFR PART 2) PROHIBIT ANY FURTHER DISCLOSURE OF THIS CONFIDENTIAL INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.