TANNER
EMPLOYEE ASSISTANCE PROGRAM

STATEMENT OF UNDERSTANDING

EAP BENEFIT AND FEES FOR SERVICE

The Tanner EAP is offered as a benefit to you by your employer. Depending on the specific contract, you may be allowed between five and eight visits per year per employee or family member. The visits are intended to provide (1) problem assessment, (2) short term counseling where appropriate and (3) referral to additional resources when necessary.

These benefits are provided at no cost to you. You are, however, responsible for any costs incurred as a result of referrals to the extent that those services may not be covered by your insurance provider.

CONFIDENTIALITY

Confidentiality is the cornerstone of any mental health service. The problems you bring to the EAP office will remain confidential and private unless you give your written permission for the counselor to share those concerns with specific other persons. **There are some exceptions that may be required by Georgia law.** Those include: (1) threats of self harm, (2) threats of harm toward others, (3) suspected abuse of children, elderly or disabled persons and (4) a valid court order. In the case of the first three, the EAP professional is ethically and legally responsible for determining whether or not information you reveal constitutes an actual threat. Your case may also be reviewed within the EAP office for the purpose of supervision, training or direction of professional staff.

In addition, some employers (i.e. public safety, DOT, aviation, nuclear power, etc.) have policies or are required by federal law to conduct fitness-for-duty evaluations as regards safety sensitive positions. As such, your EAP counselor may be required to disclose information regarding any unsafe behavior that violates those policies or regulations.

APPOINTMENTS AND HOURS OF SERVICE

In general, Tanner EAP services are provided by appointment. Walk-ins will be accepted as time permits. Should you need to cancel or reschedule an appointment we ask that you call at least 24 hours ahead in order to make that appointment time available to another client.

Our usual office hours are Monday through Friday from 8:30 AM until 5:00 PM. Additional hours may be available on a case-by-case basis. If such is the case, you should discuss that need with your counselor.

AFTER HOURS AVAILABILITY

Tanner EAP maintains after hours response 24/7 through a professional answering service. If you identify that you have a need for an immediate call back, the service will page the on-call counselor who will return your call within the hour. Otherwise, you can expect that the counselor or administrative assistant will respond to your call the next business day.

If you have a mental health or medical emergency you should contact or go to the nearest hospital emergency department for immediate assistance.

I understand the above statements and have had the opportunity to ask about and discuss any related concerns.

_____ _____

Client or Guardian Signature Date

_____ _____

Witness Date

Contract Co:	***Counselor: K – W – B***
	Relationship: Emp - Spouse - Dep

GENERAL INFORMATION

Client Name_____ Address_____

City_____ State_____ Zip_____

Home/Cell#_____may we call you at home? **Y N** may we leave a message? **Y N**

Work# _____may we call you at work? **Y N** may we leave a message? **Y N**

E-mail _____ may we contact you via e-mail? **Y N**

Race_____ Sex: F M Age_____ Date of Birth_____

Place of Birth: _____ Marital Status: **S M D W N/A** Length of Marriage_____

Education: Elementary_____ GED _____ High School_____ College_____ Graduate School_____

In the event we need to contact you, what number is best for you? (_____)_____-_____

Employment

Employer_____ Length of time with current employer_____

Job Title_____

Referral Source (answer all that apply)

Self_____ Co-worker_____ Family member_____ Human Resources_____ Physician _____

Supervisor: Encouraged_____ Required_____

Presenting Problem

What are you experiencing that led you to make this appointment?_____

_____

Has this ever been a problem before? **Y or N**

Is your present stress affecting your job performance? **Y or N**

Current Symptoms. (✓Check all that apply.)

__loss of interest			__sleep disturbance
__dizziness	__inability to enjoy life	__shortness of breath	__racing heart
__trembling	__fainting	__fatigue	__feeling smothered
__choking	__dry mouth	__feeling worthless	__thoughts of harming others
__fear of dying	__nausea	__trouble thinking	__diarrhea
__vomiting	__fear of travel	__arm/leg pain	__pressure/constriction in chest
__hot flashes	__angry outbursts	__fear of "going crazy"	__easily startled
__chills	__flashbacks	__feeling on edge	__numbness/tingling
__chest pain	__painful periods	__smothering	__loss of energy
__sweating	__low self-esteem	__irritability	__lump in throat
__forgetfulness	__restlessness	__feeling hopeless	__sudden/intense anxiety
__racing thoughts	__recent weight changes	__drinking too much	__thoughts of harming myself

Substance Abuse/Mental Health History

If you have ever used? When? Tobacco_____ Alcohol_____ Marijuana_____ Cocaine_____
Narcotics_____ Hallucinogens_____ Amphetamines_____ "Meth"_____ Other_____
Has anyone in your family ever had an alcohol or other drug problem? **Y or N**
Have you ever felt you should cut down on drinking or drug use? **Y or N**
Have people annoyed you by criticizing your drinking or drug use? **Y or N**
Have you ever felt guilty about your drinking or drug use? **Y or N**
Have you ever taken a drink or drug in the morning (as an eye opener) to steady your nerves or get rid of a hangover? **Y or N**
Is there any history of physical or sexual abuse in your family? **Y or N**
Have any family members ever had psychological or emotional problems? **Y or N**

Physical Health

Do you exercise? **Y or N** If so, how often?_____
When was your last physical? _____ Are you under the care of a physician? **Y or N**
If yes, who and what for? _____
Do you have any chronic physical problems? _____
Medications taken regularly:

Name	Reason	Dosage	Physician

Spiritual/Self Care

To whom do you turn for strength? _____
What religious practices, if any, do you find helpful?_____
What, if any, are the alternative health care practices that you routinely participate in?
_____

FAMILY INFORMATION

Spouse/Significant Other (if applicable)

Name_____ Age_____
Occupation_____ Employer_____

Children OR Siblings

NAME(s)	AGE	SEX
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parents

Mother: Living **Y or N** If yes, age_____ number of times married_____

Father: Living **Y or N** If yes, age_____ number of times married_____