PASTORAL INSTITUTE

2022 15th Avenue | Columbus, Georgia 31901
706-649-6500 | 800-649-6446 | Fax 706-649-6521

CONFIDENTIAL MANDATED REFERRAL FORM

EMPLOYER _____ Date _____

Employer Address _____

Human Resource Director _____

Other Authorized Contact _____

HR Phone _____ HR Fax _____

HR Email _____

Supervisor _____ Department _____

EMPLOYEE _____ DOB _____

Employee Address _____

Job Title _____ Employee Phone _____

Employee Email _____

This section must be completed in full by HR Director or Authorized Contact for mandated services to be assigned for scheduling.

EMPLOYEE IS: ☐ **CONTINUING TO WORK** **or** ☐ **SUSPENDED**

Issues to be addressed during mandated services:

- ☐ Emotion regulation: sadness, anxiety, moody, anger, emotions and/or outbursts affecting ability to perform job
- ☐ Communication/conflict resolution: issues with coworkers, leadership
- ☐ Home or marital issues affecting ability to perform job
- ☐ Substance use issues*: disclosure of substance use, substance use affecting ability to perform job
  - ☐ Self-reported substance use ☐ Positive drug screening
  - ☐ The above-named person has a CDL or other credential that requires a higher level of assessment.

***Please note this type of referral may require a higher level of care which would require referral to an affiliate provider in our area for assessment and treatment.**

Skills to develop during mandate: _____

☐ By checking this box, HR (as a representative of the employer) acknowledges that the mandated services provided to meet the needs specified in this referral are assigned and billed to the employer at the standard rate *in addition to* the employee's available EAP session limit as contracted with the Pastoral Institute.

The HR representative or other authorized contact will receive a report after each scheduled visit. Once treatment is complete, a treatment completion letter will be sent to the listed HR Director or Authorized Personnel.

The Human Resources Director should fax a copy of both signed forms to **888-863-0376**. A copy of this form should be sent with the employee to the first counseling session.

The referred employee will be contacted by our Counseling Programs Coordinator to schedule the initial appointment and be sent a link to our initial paperwork**. Please note the Pastoral Institute email is NOT a secure method of transmitting personal information.** If you have issues with faxing the information, please reach out to our Counseling Programs Coordinator at 706-649-6507, ext. 1208.

_____ _____
Signature of HR Representative Date

_____ _____
Signature of Employee Date

THE PASTORAL INSTITUTE
RELEASE OF INFORMATION CONSENT FORM

I,_____, hereby give my permission for the following releases of information by my therapist at the Pastoral Institute or Pastoral Institute Affiliate Provider:

Name of Therapist: _____ (To be completed by Pastoral Institute)

Check the options that apply:

☐ To release information requested between a Pastoral Institute Affiliate Provider and the Pastoral Institute, if an Affiliate Provider is working with the above-named person.

☐ To provide mandatory referral update and letter of completion to Human Resources for the above-named person.

☐ To release information **TO:** ☐ or request information **FROM**:

Name of Human Resources Director and/or Authorized Personnel: _____

HR Phone: _____ _____

HR Fax: _____ _____

This information is being released for the following reasons: **COORDINATION OF CARE FOR MANDATED REFERRAL**

☐ I understand that this release may include information regarding drug and alcohol abuse and treatment, as well as psychological and psychiatric information. (If applicable)

☐ I understand that the information to be released is protected under state and federal laws that do not permit re-disclosure without my further consent.

☐ This consent will expire 365 days from the date it is signed. Upon discharge from mandated services, this release will no longer be valid.

☐ PHI (Protected Health Information), once disclosed to others, may be re-disclosed to individuals or organizations not subject to HIPAA and may no longer be protected by HIPAA.

☐ I understand that I have the right to receive a copy of this release if requested.

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date

REVOCATION OF CONSENT

In revoking consent, I understand that this does not affect any of the ways you use my protected health information while you still had my permission to do so.

_____ _____
Signature of Witness Date Signature of Client Date