AUTHORIZATION TO EXTEND EAP SERVICES

(Beyond 6 sessions)

Case Number: _____ Date: _____

Admission Status *(check one)*: Employee ☐ Relative ☐ TFO ☐

Presenting Problem:

_____

_____

_____

Prior Mental Health History:

_____

_____

_____

Treatment Plan description (include progress to date and difficulties encountered):

_____

_____

_____

Long term treatment assessment and prognosis:

_____

_____

_____

Rationale for Extension Request:

_____

_____

_____

☐ **Requested number of extended sessions** *(max 6 per request)*

Clinician: _____ _____

(Type or print name) (Clinician Signature)

☐ *Approved* ☐ *Denied* *Number of Sessions Approved:* _____

EAP Administrator: _____ *Date:* _____