HEALTH AND HUMAN SERVICES GROUP
23392 Madero, Suite L
Mission Viejo, California 92691
1-800-275-7460 **FAX (949) 855-7575**

DEA-EAP REQUEST FOR
AUTHORIZATION TO EXTEND EAP SERVICES
(Beyond six-sessions)
Drug Enforcement Administration
Employee Assistance Program

PLEASE TYPE OR PRINT CLEARLY

Case Number: _____
Admission Status
Employee (State Discipline):_____
Relative (State Relationship):_____
Other (Please State):_____
_____
Presenting Problem:_____
_____
_____
_____
Prior Mental Health History:_____
_____
_____
Diagnosis (DX must be fully explained below; include a violence assessment statement):_____
_____
_____
_____
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. **Treatment beyond this number will require another Service Extension Request.**

Area Clinician: _____ _____
(Type or print name) (Area Clinician Signature)
Date of Extension Request:_____
Approved _____ Denied _____
EAP Administrator:_____

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