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

PLEASE PRINT CLEARLY

DEA-EAP: CONSULTATION REQUEST FORM

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Authorization Number _____

Division: _____ SAC:_____ASAC:_____RAC:_____

Address: _____Phone:_____

Date(s) of Consultation: **Type of Consultation:**

_____ **□ Management □ Organizational □ Crisis Intervention**

Purpose for Consultation: (Manager Concerns, Initial Problem Statement)

_____
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_____

Estimated Hours Required:_____ Estimated Travel Time:_____ Estimated Travel Cost:_____

Requesting Manager's Name: **_____**

Area Clinician Requested

Printed
_____ **_____**
Printed **Signature**

Review of Request: **_____ Date: _____**
Nels Klyver, Ph.D. Administrative Clinician

Hours Approved: _____

□ DENIED **_____**