**HEALTH AND HUMAN SERVICES GROUP**
**25108 Marguerite Parkway, Ste. B – # 505**
**Mission Viejo, CA 926921-800-467-3277**
**Fax 949-768-1667**

**Submit With Last Bill**

***PLEASE PRINT CLEARLY***

**U.S. DEPARTMENT OF HOMELAND SECURITY**
**OFFICE OF BORDER PATROL (OBP) EAP**

## ADMISSION/DISCHARGE

**ADMIT DATE**_____

**Case #:**_____ **Type of Referral: FORMAL INFORMAL POSITIVE DRUG SCREEN**
**Provider Name:**_____ **SSN:**_____ **Region: C E W HQ**
**Client SSN:**_____ **Sessions Authorized: ____ Sessions Extended: ____ Authorization #:**_____
**Client Name:**_____ **DOB:**_____**Age:**_____ **Religion:** _____
**Employee Relative (Relationship)** _____ **Marital Status: Married Single Separated Divorced Widowed**
**Job Title:**_____ **Grade (GS Level):** _____ **EOD:**_____ **Shift Work: YES NO**
**Current Address:** _____ **Work Address:** _____
_____ _____
**Home Phone: (____)** _____ **Work Phone: (____)** _____
**Spouse Address (If Different)**_____
**Home Phone: (_____)** _____ **Work Phone: (_____)** _____ **Family Composition:** _____

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**Health Insurance Company:** _____ **ID #**_____
_____**T**
**elephone: (_____)** _____ **Mental Health Coverage: Inpatient** _____ **Outpatient**_____

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**PROBLEM STATEMENT/SYMPTOM DESCRIPTION: (If more space is needed, please attach notes to this document)** _____
_____
_____
_____
_____

**DIAGNOSIS (DSM IV): Axis I:** _____ **Axis II:** _____ **Axis III:**_____
**Axis IV:**_____ **Axis V:** _____
**TREATMENT PLAN/GOALS: (Note Treating practitioner/organization; attach page if needed)** _____
_____
_____
_____
_____
_____

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**DISCHARGE INFORMATION: Date:**_____ **# of Sessions Used:** _____ **Pt. Status: Improved Not Improved Too Soon to Tell. Was continued care recommended? ρ YES ρ NO. Explain: (If more space needed attach notes to this document)** _____
_____
_____
_____
_____ **DX (If changed) Axis I:** _____ **Axis V:** _____

**FOLLOW-UP PLAN**: (Please note projected dates and follow up calls.) _____
_____
_____
_____

**DURING COURSE OF TREATMENT REFERRALS WERE MADE TO:**
**(Check All That Apply)**
**InPt MH/SA Facility**
**Specialized OutPt/Partial Services**
**Physician Services (Medical)**
**Attorney/Legal Services**
**Financial Aid Resources**
**Self-Help Groups (AA, NA, Al Anon, etc.)**
**Child Care Resources**
**Involuntary Hold Facility**
**Other (Explain)**

**REASON FOR DISCHARGE**
**(Check All That Apply)**
**Evaluation/Assessment Only (1-3 Sessions)**
**Referred to Other Provider**
**Treatment Goals Partially/Competely Met**
**Referred to HMO/PPO?OWC? for Continued TX**
**Referred to Specialized InPt/OutPt Services**
**Client Withdrew Against Clinician Advice**
**Client Continued Under Another Benefit**
**Admitted to Involuntary Hold Facility**
**Client Unable to Continue (Explain)**

**PERFORMANCE PROBLEM CATEGORIES**
**(Check All That Apply)**
**Absenteeism/Tardiness**
**Work Relationships**
**Quality and Quantity of Work**
**Problems With Other Employees**
**Misconduct**
**Other (Explain)**