Employee Assistance Programme (EAP) Service Referral Form

All information provided to EAP is treated with confidentiality

Details of staff member being referred

Name		***Correspondence Address and Eircode***
Date of Birth		
Mobile No		***Work Location***
E-mail		***Please list any special requirements you may have:***
Job Title		

Have you used the service before: ***Yes*** ☐ ***No*** ☐

Preferred contact method: ☐ ***Mobile number*** ☐ ***E-mail address***

Availability *(Please note every effort will be made to accommodate your preference)*

Morning	☐	Monday	☐	Tuesday	☐	Wednesday	☐	Thursday	☐ Friday
Afternoon	☐	Monday	☐	Tuesday	☐	Wednesday	☐	Thursday	☐ Friday

Work Category

Admin/Clerical	☐	***General Support Staff***	☐	***Student/Trainee***	☐
Allied Health	☐	***Medical/Dental***	☐	***Does not wish to disclose***	☐
Ambulance Paramedic	☐	***Nursing & Midwifery***	☐		
Director/Snr Manager	☐	***Technical Science***	☐		

Directorates

CHO	☐	***Children's Hospital Group***	☐	***Dublin Midlands***	☐
Ireland East	☐	***National/Corporate***	☐	***HBS***	☐
NAS	☐	***UL Hospital***	☐	***RCSI***	☐
Saolta	☐	***SW Hospital***	☐		

Emergency Contact	
Emergency Contact Name	
Emergency Contact Phone No	
Emergency Contact Relationship	

GP Details	
GP Name	
GP Address	
GP Telephone No	

Reason for Referral

Please provide brief details (avoid mentioning names)

Referrer Information

Self-referral: ☐	***Occupational Health:*** ☐	***Line Manager:*** ☐	***Other:*** ☐

Leave blank if Self-Referral

Referrer Name (Block Caps):

Grade:

Location and contact details:

Referrer Signature: ***Date:***

Employee's Consent

I agree to the EAP Service confirming my attendance at the first session/meeting with the referring party ☐	
Signature: _____	***Date:*** _____