

**EMPLOYEE ASSISTANCE PROGRAM  
CONSENT FOR INDIVIDUAL FOLLOW-UP**

Date of Referral: \_\_\_\_\_ Case Number: \_\_\_\_\_

Company Name: \_\_\_\_\_

EAP Name: \_\_\_\_\_

Incident Manager: \_\_\_\_\_

**EMPLOYEE INFORMATION:**

Employee Name: \_\_\_\_\_

Gender: Male / Female

Address: \_\_\_\_\_

Email address: \_\_\_\_\_

Cell or Home number: \_\_\_\_\_ Can a message be left on voicemail? Yes / No

Work number: \_\_\_\_\_ Can a message be left on voicemail? Yes / No

By signing this form I consent to a follow-up call from an EAP counselor within **5 days** of today's date.

**URGENT REQUEST:** I consent to a follow-up call from an EAP counselor within **48 hours** of today's date.

Signature: \_\_\_\_\_

Today's date: \_\_\_\_\_