

Empathia Assessment and Outcome Form

Use this form only for the case indicated below

Instructions: Please complete and return with the Empathia Clinical Reimbursement Form.

Client Name: _____ Case Number: _____

Assessed Problems/Risk Assessment

Please notify Empathia regarding cases involving any high risk concerns, requests for documentation (e.g. FMLA or Short Term Disability), or requests for consultation with the client's employer.

Primary Concern (Write in the code from the list below that fits best.) Code (1-27): _____

Secondary Concern (Write in the code from the list below that fits best.) Code (1-27): _____

- | | | |
|---|----------------------------------|--|
| 01 Suicidal Thoughts/Plans | 09 Stress | 19 Medical Condition |
| 02 Homicidal Thoughts/Plans | 10 Work Issues | 20 Post-Traumatic Stress |
| 03 Abuse or Neglect | 11 Situational/Adjustment Issues | 21 Psychotic Episode |
| 04 Substance Abuse/Dependence (recommend use of validated substance use screening tool) | 12 Anxious Mood | 22 Spiritual Issues |
| 05 Other Addictive Behaviors (e.g. sex, Internet, gambling, etc.) | 13 Depressed Mood | 23 Trauma |
| 06 Eating Disorders | 14 Bereavement | 24 Financial (refer back to EAP) |
| 07 Domestic Violence | 15 Relationship Issues | 25 Legal (refer back to EAP) |
| 08 Anger Management | 16 Family Issues | 26 Child Care/Elder Care (refer back to EAP) |
| | 17 Adolescent Issues | 27 Other _____ |
| | 18 Children's Issues | |

GAF Score

Current Score _____

- 81-100: no symptoms
68-80: mild symptoms
51-60: moderate symptoms
31-50: serious symptoms, impairment in reality testing or major impairment in multiple areas
Below 30: serious impairment in communication or judgment, or hallucinations, delusional or almost unable to function in most areas

Case Status

(check the one that applies)

___ **Ongoing Treatment**

___ **Case Closed** (check reason below):

- ___ Assessed problem resolved conclusively within EAP services.
___ Client required a referral beyond EAP services.
___ Client does not want or need additional services at this time.
___ Client terminated EAP services before completion of assessment.

Clinical Goals Status

(scale 1-5; enter number from scale below)

Clinical Goals:

- | | |
|----------|---------------|
| 1. _____ | Goal 1: _____ |
| 2. _____ | Goal 2: _____ |
| 3. _____ | Goal 3: _____ |

Goal Status: ABOVE, indicate goal attainment status at the time of paperwork submission.

1. Goal met 2. Goal partially met 3. No change 4. Condition worsened 5. Client terminated prior to completion of assessment

Referral(s) Offered

Referral Code _____

- | | | |
|---|-----------------------------------|--------------------------------|
| 01 EAP Only | 04 Legal (refer back to Empathia) | 08 Medication Evaluation |
| 02 Self Referral (fill out Freedom of Choice Affidavit) | 05 Support Group | 09 Inpatient/IOP Mental Health |
| 03 Financial (refer back to Empathia) | 06 Outpatient Mental Health | 10 Inpatient/IOP AODA |
| | 07 Outpatient AODA | 11 Other _____ |

Empathia requires that you offer to facilitate referrals for EAP clients. Please check all steps completed:

- | | |
|--|---|
| ___ Referral assistance offered but declined | ___ Assessment information passed to referral resource |
| ___ Insurance checked/verified | ___ Follow up with client to determine satisfaction with referral |
| ___ Referral to an in-network provider | ___ Treatment pre-certified with insurance |
| ___ Client preferred to remain in treatment with EAP provider; client signed the Freedom of Choice Affidavit form after having been offered referral options | |

Signature of Provider

Date

Printed Name of Provider

Provider's Individual NPI #

Questions? Please call 877-844-8693

Return to: Empathia, N17 W24100 Riverwood Drive, Ste. 300 Waukesha, WI 53188 or fax to 262-523-0175