

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 | 13 Depressed Mood | 23 Trauma |
| Addictive Behaviors | 14 Bereavement | 24 Financial (refer back to EAP) |
| (e.g. sex, Internet, gambling, etc.) | 15 Relationship Issues | 25 Legal (refer back to EAP) |
| 06 Eating Disorders | 16 Family Issues | 26 Child Care/Elder Care (refer back to EAP) |
| 07 Domestic Violence | 17 Adolescent Issues | 27 Other _____ |
| 08 Anger Management | 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

Clinical Goals: (scale 1-5; enter number from scale below)

Status:

- | | |
|----------|---------------|
| 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 Code _____

Referral(s) Offered

- | | | |
|---|-----------------------------------|--------------------------------|
| 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. 150 Waukesha, WI 53188 or fax to 262-523-0175

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