Fax to: Kaitlin Blanco-Silva 803-929-0762

POST ASSESSMENT SUMMARY

Due on completion of assessment

Please notify EAP immediately of any failure to comply or failure to attend sessions at 803-929-0661

RE: PATIENT DOB:

Date of Assessment:

Diagnosis:

Treatment recommendations: (select all that apply)

☐ Individual Counseling ☐ Education/Therapy Group ☐ IOP ☐ Family Counseling

☐ Group Counseling ☐ In-patient (where) ☐ Referred Out (where)

Start Date of Tx: Frequency: Estimated End Date:

If in group, check the days the group meets: ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

If group, time of group meetings:

Typical session length: Projected number of sessions needed:

Drug screen: Date of screen: Results:

COUNSELOR IMPRESSIONS/NOTES:

Counselor's Signature: _____ Credentials:

Counselor's Phone Number:

Date Counselor's Address: