

DOR

Drug- Free Workplace/Positive Drug Screen Referrals (non DOT)

Some companies require employees to participate in drug screening as a condition of their employment. This is especially true for federal agencies and their contracts. A Drug-Free Workplace policy is a written policy, including a clear statement of expectations for workplace behavior, prohibitions against reporting to work or working under the influence of illegal drugs or alcohol, prohibitions against the use or possession of illegal drugs in the workplace and the consequences of violating those expectations and prohibitions.

1. If an employee tests positive for drugs or alcohol, the supervisor and employee will make the initial contact with the intake coordinator at **DOR**. If a supervisor or employee calls you directly, please refer them to **DOR**.
2. You will receive documentation relevant to the referral including:
 - Authorization and dor paperwork
 - Reason for drug test (i.e. due to probable cause)
 - The positive drug test report (if possible)
 - Number of sessions available
 - Client company Drug Free Workplace policies
3. Clinical Procedures:
 - Screen for issues of chemical dependency, abuse and use.
 - Recommend referral at the appropriate level of care.
 - Help the client to connect to those resources.
 - Have employee sign a **DOR** release of information for supervisor follow-up. You cannot call the supervisor if the release is not signed.
 - Call the supervisor to confirm the employee's attendance and to state your recommendations and follow up plans within 24 hours after the initial appointment.
 - Fax a copy of your assessment and recommendation letter to the supervisor (see attached sample letter) to **DOR** for review within 72 hours after the initial appointment. We will review it and return the fax to you with any necessary changes.
 - Using your letterhead, mail your assessment and recommendation letter to the supervisor.
 - Initiate case management and follow up, as the client company policies require.

Please fax to us your letter of written recommendations. We will review this with you.

Our fax number is 612-342-2422

Remember : Consultation with DOR is always available by calling 1-800-367-3271.

As an affiliate you are always reimbursed for all case management.

D	O	R	Delivering Organizational Results	1660 South Highway 100 Suite 430 Minneapolis, MN 55416	612-332-4805 800-367-3271	Fax: 612-342-2422 www.doreap.com doreap@doreap.com
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**RELEASE OF INFORMATION FORM
DRUG FREE WORKPLACE REFERRAL**

I hereby authorize **DOR** to share the following information:

1. Confirm to employer dates of session attendance
2. Confirm to employer any anticipated follow-up or case management information
3. Please specify any additional information to be shared _____

with (company, agency, individual) _____

address _____

I understand that such information will be confidential and used by professional persons interested in the welfare of the above named individual. I also agree that the photocopy of this release form has the same validity as the original. Material released by **DOR** is not to be re-released by the agency requesting such information.

Print Name

Signature of client, parent or guardian

Date

Valid Until _____

Therapist Name

D O R	Delivering	1660 South Highway 100	612-332-4805	Fax: 612-342-2422
	Organizational	Suite 430	800-367-3271	www.doreap.com
	Results	Minneapolis, MN 55416		doreap@doreap.com

**Sample Letter
for
Drug - Test Positive Assessments**

Dear _____,
Employer Contact

This letter is to inform you that I have met with _____ on _____.
Client date

The employee was referred as a result (e.g. self-disclosure of alcohol and cocaine use).

I have recommended that the employee participate in _____ (e.g. treatment, education etc.)
Level of care

through _____. Client is scheduling to begin _____ on _____.
Name of referral agency level of care date

I will continue to follow up on the employee's progress. Feel free to call if you have any questions.

Sincerely,

EAP Counselor

**Please fax to us your letter of written recommendations. We will review this with you.
Our fax number is 612-342-2422**

CHEMICAL HEALTH INTAKE
CLIENT INFORMATION

Date:

Last Name: **First Name:** **Middle Name:** **Birth date:**

Address: () _____ () _____
Home Phone Number: **Work Phone Number:**

City: **State:** **Zip Code:** **Social Security Number:**

Health Insurance Coverage: **Health Insurance Policy/ID Number:**

Company/Organization: **City:** **State:**

Occupation/Department: **Title:** **Current Job Status:**

Referring Supervisor's Name: **Phone Number:**

Referring Supervisor's Address **City:** **State:** **Zip Code:**

Tested Positive for:	Alcohol: Level _____	Drug: Type _____
Type of Test:	<input type="checkbox"/> Pre-placement (Drug only)	<input type="checkbox"/> Reasonable suspicion
	<input type="checkbox"/> Return-to-duty	<input type="checkbox"/> Post-accident
	<input type="checkbox"/> Follow-up	<input type="checkbox"/> Random

Place a check by the substances you have used :

Ever in your life	within the last 12 months		Ever in your life	within the last 12 months	
_____	_____	Alcohol	_____	_____	Other Amphetamines
_____	_____	Cocaine	_____	_____	Other Stimulants
_____	_____	Crack	_____	_____	Over the Counter drugs
_____	_____	Codeine	_____	_____	Benzodiazepines (Bennies)
_____	_____	Heroin	_____	_____	Other Tranquilizers
_____	_____	Non-prescrip Methadone	_____	_____	Barbiturates (Downers)
_____	_____	Other Opiates/Synthetics	_____	_____	Other Sedatives/Hypnotics
_____	_____	Marijuana/Hash	_____	_____	Inhalants (glue, paint, poppers)
_____	_____	PCP	_____	_____	Nicotine/Tobacco
_____	_____	LSD/ Acid	_____	_____	Other (Special K, Extasy, etc...)
_____	_____	Other Hallucinogens	_____	_____	Caffeine
_____	_____	Metha-amphetimene (Crystal Meth)	_____	_____	

1. Is there a history of chemical abuse, drug addiction, alcoholism in your family? Yes No (circle)

Please explain:

2. Is there a history of mental illness in your family? (For example: "nervous breakdown" depression,) Yes No

Please explain:

3. Please list any current medical problems:

4. Please list any medications you are currently taking:

STATEMENT of UNDERSTANDING

DOR provides evaluation of personal problems, short term counseling, management consultation, referral and follow-up services. It is important that before you proceed with this process you understand the following limits.

Confidentiality

All contact with **DOR** is a private communication. Your appointment and the nature and content of your appointment can not be revealed to anyone, e.g., family members or employer. Exceptions must be made in the following circumstances.

1. A client can give permission to disclose through a signed *release of information* form. This form is your permission to release information to whomever you have designated. The release must be to a specific person or clinic, e.g., your supervisor or another therapist.
2. According to state law, all counselors are required to report suspected child abuse, child neglect or abuse of an adult who is not competent to conduct their own affairs. These reports are made to the appropriate county or state agency.
3. According to state law, if a client threatens suicide, a counselor must seek help for that person by reporting to family, police or other community resources. If a person threatens to physically harm another person, the counselor must report this to local authorities and to the intended victim.
4. The privilege of confidentiality for minors (under 18) is held by the parents, guardian or parent with custody. Information from a session may be shared with the holder of the privilege. Emancipated minors are an exception. Information about an emancipated minor may be shared with parents/or guardian if failure to report endangers that minor.
5. HIPAA Compliance. **DOR** is confident of our security and compliance with HIPAA regulations regarding client confidentiality.

If you have concerns about what you can or can not discuss in a session speak with your Employee Assistance Counselor. You may first want to discuss this in general terms and then the counselor can help you decide how this may or may not apply to your specific situation.

Referrals

In some cases, a referral to another service or resource outside of the EAP may be offered to you. These referrals are suggestions: the decision to use or not to use these resources are at your discretion. The cost for these resources is outside of the EAP service and you will be responsible for any fees incurred.

I have read and understand the above statement. :

Signature