

EAP Case Closing Summary

Client Name _____ Social Security Number _____
 # Sessions in benefit: (check one) 3 5 6 8 # EAP Session Used: _____
 # No Shows (A "No Show" is defined as missed scheduled appointment without notification): _____
 Dates of No Shows: _____

Status at Case Closing			
Job Performance Problems	Other Problems	Job Status	Releases Signed
<input type="checkbox"/> Problem Resolved	<input type="checkbox"/> Problem Resolved	<input type="checkbox"/> Same/Active	<input type="checkbox"/> Statement of Understanding
<input type="checkbox"/> Some Improvement	<input type="checkbox"/> Some Improvement	<input type="checkbox"/> Promoted	<input type="checkbox"/> Other releases signed:
<input type="checkbox"/> Significant Improvement	<input type="checkbox"/> Significant Improvement	<input type="checkbox"/> Terminated	
<input type="checkbox"/> No Change	<input type="checkbox"/> No Change	<input type="checkbox"/> Quit	
<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	
<input type="checkbox"/> Undetermined	<input type="checkbox"/> Undetermined	<input type="checkbox"/> Undetermined	
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other	

Case Disposition and Referral				
A. Case Disposition (fill in all that apply)	B. Referral			
	Substance Abuse	Psychiatric	Community	Other
<input type="checkbox"/> Face-to-face assessment/no referral				
<input type="checkbox"/> Face-to-face assessment/referral accepted	<input type="checkbox"/> SA Evaluation	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Self-help (SA)	<input type="checkbox"/> EAP Only
<input type="checkbox"/> Face-to-face assessment/referral declined	<input type="checkbox"/> Outpatient SA	<input type="checkbox"/> Partial hospital	<input type="checkbox"/> Self-help (other)	<input type="checkbox"/> MH Benefit
<input type="checkbox"/> EAP participant withdrew before completion of services	<input type="checkbox"/> Intensive Outpt.	<input type="checkbox"/> Outpt. (non-MD)	<input type="checkbox"/> Work/family	<input type="checkbox"/> Therapist Managed Case After Referral
<input type="checkbox"/> Information Contact Only	<input type="checkbox"/> Inpatient Detox	<input type="checkbox"/> Outpt. (MD)	<input type="checkbox"/> Financial/Legal	<input type="checkbox"/> Therapist Referred to Self
<input type="checkbox"/> Undetermined	<input type="checkbox"/> Inpatient Rehab	<input type="checkbox"/> Other:	<input type="checkbox"/> Human Resources	
<input type="checkbox"/> Other (Specify):	<input type="checkbox"/> Other:		<input type="checkbox"/> Comm/Co. Resources	
			<input type="checkbox"/> Other:	

Comments: _____

Resource names and addresses given to EAP participant: _____

If referral was made, was linkage to referral source confirmed? Yes No

How? _____

CLOSING DIAGNOSIS (if applicable) (Please Enter DSM IV Codes) N/A	
Axis I: Code: _____ Diagnosis: _____	
Code: _____ Diagnosis: _____	
Axis II: Code: _____ Diagnosis: _____	
Axis III: Medical Condition(s): _____	
Axis IV: (Stressors) _____	Axis V: Current GAF: _____

For Last Session Billing: (closing Summary must be submitted for last session reimbursement)	
Date of Last Session: _____	Session #: _____ CPT Code for last session: _____
CPT Code:	
90801 0 Comprehensive Evaluation	90853 - Group Psychotherapy (90 min)
90843 - Psychotherapy (20 - 30 min)	90862 (90805) - Medication Management (20-30 min)
90844 (90806) - Psychotherapy (45 - 50) min)	99243 - Psychiatric Evaluation (60 min - use for adults only)
90847 - Family/Marital (45 - 55 min)	99243-22 - Psychiatric Evaluation (90 min - use for children only)
EAP Clinician Signature _____	Date _____