Peoples Oakland
Employment Assistance Program (EAP)
REFERRAL FORM

Date of Referral: _____

Customer Name: _____ Client ID #: _____

Race: _____ Living Arrangement: _____

Social Security # _____ Date of Birth: _____

Address: _____ Customer Phone (H): _____

_____Customer Phone (C): _____

Referral Source Name: _____ Phone #:_____

Referral Source Agency: _____ Referral Source email: _____

Case Manager: _____ Phone: _____

Clinician: _____ Phone: _____

Other contacts: _____ Phone: _____

Diagnosis: _____ ICD 10 #: _____

Consumer is currently receiving services through what agency(s)? _____

Current OVR case opened: yes _____ no _____ OVR Counselor: _____

What type of work is the person interested in? _____

Are there any physical limitations? _____

Is there a criminal history? _____

Any substance abuse issues? _____

Please include Psychiatric Evaluation with Referral Form.
[NOTE: In lieu of a Psychiatric Evaluation, submit a treatment plan that lists diagnosis and is signed by a Psychiatrist or Psychologist.]

**** Please forward Referral Form and Psychiatric Evaluation to:**
Elise Barr
3433 Bates Street, Pittsburgh PA 15213
Office: 412-683-7140 x222 Fax: 412-683-7138 Email: **eliseb@peoplesoakland.org**
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Date received: _____ Initial Contact: _____

Updated 3/2019