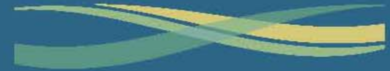
Shepell·fgi™



work. health. life.

Welcome to Shepell·fgi counselling.

Shepell·fgi is pleased to provide you with professional, confidential counselling. Prior to your 1st session with your counsellor, please take a moment to complete pages 2-6 of the clinical record. Your counsellor will be able to discuss any questions or concerns that you may have.

Thank you for your time.

EMPLOYEE ASSISTANCE PROGRAM
Statement of Understanding

It is important that you understand the confidential nature of your relationship with your Shepell·fgi counsellor. No one at Shepell·fgi will release your name or any information about you or your counselling to anyone outside of Shepell·fgi without your informed, voluntary, and written consent, except as outlined below:

- When we are required by law to disclose what would otherwise be confidential information, such as when we believe you may pose a risk of serious injury to yourself or others, there is suspicion of child abuse as defined by applicable government legislation or we are served with a properly executed court order.
- If you occupy a safety sensitive position in your workplace your counsellor may be obliged to report drug and alcohol concerns to your company's Occupational Health provider in order to ensure employee and public safety.
- Third party professional auditors may examine files to evaluate the EAP. These auditors will not be employees of Shepell·fgi or your organization. Your use of the EAP will not be disclosed to your organization or any other party.

Shepell fgi is compliant with all Provincial, Federal and International privacy requirements, including HIPAA, Safe Harbour and a Privacy Officer. You may view our privacy policy online at www.shepellfgi.com, or request a hard copy by calling the EAP number. If you have any concerns about our services, please contact the EAP number and ask to speak with a Supervisor. We are available 24/7 to assist you.

Program Eligibility: The EAP counselling program offers assessment, counselling, and referrals, when necessary. It is your responsibility to determine whether your employer, insurer or government health plan covers the cost of services referred to outside the EAP.

Cancellation Policy: We require that all clients provide their counsellor with at least 24 hours notice of an appointment cancellation.

Counselling: The EAP provides short term counselling. These services are most appropriate for people who have identified a specific concern and are prepared to work actively, with the help of a professional counsellor, toward implementing an action plan to resolve it. Because the specific number of hours needed may vary, the EAP is designed to work with an average range of hours consistent with the short-term approach. The EAP does not provide long term counselling. When this type of service appears appropriate, counsellors will refer to public or private resources offering longer term or more specialized services. EAP counsellors cannot advocate on your behalf in legal or work-related matters. If you require a copy of your file, you will be charged a processing fee. Please contact your EAP to make this request. Upon written request, any person participating in counselling may have access to the Clinical File for the meetings at which they were present.

Satisfaction Survey: Your counsellor will provide you with a Satisfaction Survey. Please take the time to complete and return it as soon as possible. Your feedback is important to Shepell·fgi.

I have read, or had this statement read to me, and acknowledge its conditions. In signing, I also confirm my eligibility for the program.

______________________________	______________________________
Signature	*Date*
______________________________	______________________________
Signature	*Date*
______________________________	______________________________
Witness	*Date*

Shepell·fgi reserves the right to use client information for statistical and research purposes regarding EAP trends. All information collected will be entirely non-identifying and complete confidentiality will be maintained. Shepell·fgi will continue to provide services regardless of your participation in research.

A photocopy or facsimile of this authorization shall be as valid as the original.

CLIENT COPY
EMPLOYEE ASSISTANCE PROGRAM
Statement of Understanding

It is important that you understand the confidential nature of your relationship with your Shepell·fgi counsellor. No one at Shepell·fgi will release your name or any information about you or your counselling to anyone outside of Shepell·fgi without your informed, voluntary, and written consent, except as outlined below:

- When we are required by law to disclose what would otherwise be confidential information, such as when we believe you may pose a risk of serious injury to yourself or others, there is suspicion of child abuse as defined by applicable government legislation or we are served with a properly executed court order.
- If you occupy a safety sensitive position in your workplace your counsellor may be obliged to report drug and alcohol concerns to your company's Occupational Health provider in order to ensure employee and public safety.
- Third party professional auditors may examine files to evaluate the EAP. These auditors will not be employees of Shepell·fgi or your organization. Your use of the EAP will not be disclosed to your organization or any other party.

Shepell fgi is compliant with all Provincial, Federal and International privacy requirements, including HIPAA, Safe Harbour and a Privacy Officer. You may view our privacy policy online at www.shepellfgi.com, or request a hard copy by calling the EAP number. If you have any concerns about our services, please contact the EAP number and ask to speak with a Supervisor. We are available 24/7 to assist you.

Program Eligibility: The EAP counselling program offers assessment, counselling, and referrals, when necessary. It is your responsibility to determine whether your employer, insurer or government health plan covers the cost of services referred to outside the EAP.

Cancellation Policy: We require that all clients provide their counsellor with at least 24 hours notice of an appointment cancellation.

Counselling: The EAP provides short term counselling. These services are most appropriate for people who have identified a specific concern and are prepared to work actively, with the help of a professional counsellor, toward implementing an action plan to resolve it. Because the specific number of hours needed may vary, the EAP is designed to work with an average range of hours consistent with the short-term approach. The EAP does not provide long term counselling. When this type of service appears appropriate, counsellors will refer to public or private resources offering longer term or more specialized services. EAP counsellors cannot advocate on your behalf in legal or work-related matters. If you require a copy of your file, you will be charged a processing fee. Please contact your EAP to make this request. Upon written request, any person participating in counselling may have access to the Clinical File for the meetings at which they were present.

Satisfaction Survey: Your counsellor will provide you with a Satisfaction Survey. Please take the time to complete and return it as soon as possible. Your feedback is important to Shepell·fgi.

I have read, or had this statement read to me, and acknowledge its conditions. In signing, I also confirm my eligibility for the program.

Signature ______________________________ *Date* ______________________________

Signature ______________________________ *Date* ______________________________

Witness ______________________________ *Date* ______________________________

Shepell·fgi reserves the right to use client information for statistical and research purposes regarding EAP trends. All information collected will be entirely non-identifying and complete confidentiality will be maintained. Shepell·fgi will continue to provide services regardless of your participation in research.

A photocopy or facsimile of this authorization shall be as valid as the original.

Please describe your main reason for counselling:

If not identified above, do you have any of the following concerns?

Describe:

Medical ☐ Yes ☐ No ______________________________

Financial ☐ Yes ☐ No ______________________________

Legal ☐ Yes ☐ No ______________________________

Have you ever had counselling before? ☐ Yes ☐ No

Have you ever been hospitalized for a mental health issue? ☐ Yes ☐ No

Please specify what year and reason: ______________________________

Are you presently off work for medical reasons? ☐ Yes ☐ No

If Yes:

☐ Sick Leave
☐ Short Term Disability
☐ Long Term Disability
☐ Worker's Compensation
☐ Off work since what date? ______________________________

During the last 12 months how often and how much did you use:					
	Never	Less than once per month	1 to 3 times per month	1 to 2 times per week	3 times per week or more
Alcohol (Standard drinks)					
Cannabis					
Cocaine					
Other drugs (Specify)					
Prescription medications (Specify)					
Tobacco					

Standard Drinks (SD)

Spirits (40%)	**Beer (5%)**	**Wine (12%)**
43 ml (= 1 ½ oz) = 1 SD 375 ml (= 13 oz) = 9 SD 750 ml (= 26 oz) = 18 SD	1 small (341 ml) = 1 SD 1 king can (750 ml) = 2 SD 1 boss (950 ml) = 3 SD	1 glass (5 oz/142 ml) = 1 SD ½ litre = 3.5 SD bottle (750 ml) = 5 SD

Are you concerned about your alcohol or drug use? Yes ☐ No ☐

Are others concerned about your alcohol or drug use? Yes ☐ No ☐

Have you experienced negative consequences as a result of your use? Yes ☐ No ☐

If yes, describe: ______________________________

MDI- 10						
During the past two weeks, how much of the time	**All the time**	**Most of the time**	**Slightly more than half the time**	**Slightly less than half the time**	**Some of the time**	**At no time**
1. Have you felt low in spirits or sad?	5☐	4☐	3☐	2☐	1☐	0☐
2. Have you lost interest in your daily activities?	5☐	4☐	3☐	2☐	1☐	0☐
3. Have you felt lacking in energy and strength?	5☐	4☐	3☐	2☐	1☐	0☐
4. Have you felt less self-confident?	5☐	4☐	3☐	2☐	1☐	0☐
5. Have you had a bad conscience or feelings of guilt?	5☐	4☐	3☐	2☐	1☐	0☐
6. Have you felt that life wasn't worth living?	5☐	4☐	3☐	2☐	1☐	0☐
7. Have you had difficulty in concentrating, e.g. when reading the newspaper or watching television?	5☐	4☐	3☐	2☐	1☐	0☐
8a Have you felt very restless?	5☐	4☐	3☐	2☐	1☐	0☐
8b. Have you felt subdued or slowed down?	5☐	4☐	3☐	2☐	1☐	0☐
9. Have you had trouble sleeping at night?	5☐	4☐	3☐	2☐	1☐	0☐
10a. Have you suffered from reduced appetite?	5☐	4☐	3☐	2☐	1☐	0☐
10b. Have you suffered from increased appetite?	5☐	4☐	3☐	2☐	1☐	0☐

Pre/Post Assessment

Counsellor ID ☐☐☐☐☐☐☐☐☐☐ Activity Number ☐☐☐☐☐☐☐☐☐☐

Please read each question carefully and choose the one response that best represents your answer. This information is confidential and your treatment will be in no way affected by your decision to participate or by your answers.

Proper Marks ■ ☒ | Improper Marks ☑ ☒

PRE COUNSELLING ASSESSMENT	Poor	Fair	Good	Very Good	Excellent
In general, would you say your health is:	☐	☐	☐	☐	☐
In general, would you say your mental health is:	☐	☐	☐	☐	☐
	None of the time	Some of the time	Half of the time	Most of the time	All of the time
Please indicate in the amount of time in the past 4 weeks that the problem that brought you to EAP interfered with your ability to do your job.	☐	☐	☐	☐	☐

During the past 4 weeks, how many working hours have you been absent, late, or left early, not including vacation? *(Please select one)*

☐ Less than 4 hrs ☐ 4 - 8 hrs ☐ 9 - 12 hrs ☐ 13 - 16 hrs ☐ 17 - 20 hrs ☐ 21 - 24 hrs

☐ 25 - 28 hrs ☐ 29 - 32 hrs ☐ 33 - 36 hrs ☐ 37 - 40 hrs ☐ 41 - 56 hrs ☐ 57 - 88 hrs

☐ 89 - 120 hrs ☐ 121 - 152 hrs ☐ Greater than 152 hrs

Please stop here, the following section will be completed at the last session.

POST COUNSELLING ASSESSMENT	Poor	Fair	Good	Very Good	Excellent
In general, would you say your health is:	☐	☐	☐	☐	☐
In general, would you say your mental health is:	☐	☐	☐	☐	☐
	None of the time	Some of the time	Half of the time	Most of the time	All of the time
Please indicate in the amount of time in the past 4 weeks that the problem that brought you to EAP interfered with your ability to do your job.	☐	☐	☐	☐	☐

During the past 4 weeks, how many working hours have you been absent, late, or left early, not including vacation? *(Please select one)*

☐ Less than 4 hrs ☐ 4 - 8 hrs ☐ 9 - 12 hrs ☐ 13 - 16 hrs ☐ 17 - 20 hrs ☐ 21 - 24 hrs

☐ 25 - 28 hrs ☐ 29 - 32 hrs ☐ 33 - 36 hrs ☐ 37 - 40 hrs ☐ 41 - 56 hrs ☐ 57 - 88 hrs

☐ 89 - 120 hrs ☐ 121 - 152 hrs ☐ Greater than 152 hrs

1. Client completed depression screening: ☐ Yes ☐ No

MDI score: _ __________ MDI score (second client)_ __________

As a severity measure, the MDI score ranges from 0 to 50, since each of the 10 items can be scored from 0 (at no time) to 5 (all the time). *For items 8 and 10, alternative a or b with the highest score is considered.*

Mild depression symptoms	Total score of 20 - 24
Moderate depression symptoms	Total score of 25 - 29
Severe depression symptoms	Total score of 30 or more

2. Risk of suicide: ☐Yes ☐No ☐ Previous attempt ☐ Ideation ☐ Intent ☐ Plan

3. Risk of self-harm/injury: ☐Yes ☐No ☐ Previous attempt ☐ Ideation ☐ Intent ☐ Plan

4. Risk of harm to/from others: ☐Yes ☐No ☐ Previous attempt ☐ Ideation ☐ Intent ☐ Plan

Describe:

5. If yes, indicate risk factors:

☐ Addiction
☐ Child abuse
☐ Childhood abuse
☐ Family history of suicide/violence
☐ Hopelessness
☐ Impaired judgment
☐ Lack of social support
☐ Previous MH/SA hospitalization
☐ Previous suicide attempt
☐ Other ________________
☐ Recent loss
☐ Safety sensitive occupation
☐ Self-injury/spouse abuse

NB: If assessment indicates child abuse, risk of harm to self or others, or serious psychological or emotional deterioration, consultation with Clinical Supervisor/Manager is mandatory.

6. Is there a duty to report? ☐ Yes ☐ No

7. Actions taken by counsellor *(Check where appropriate):*

Informed Clinical Supervisor/Manager:	☐ Yes	☐ No	Date:	Time:	AM / PM
Others informed:					
♦ Potential Victim:	☐ Yes	☐ No	Date:	Time:	AM / PM
♦ Police:	☐ Yes	☐ No	Date:	Time:	AM / PM
♦ Child Welfare:	☐ Yes	☐ No	Date:	Time:	AM / PM
♦ Referred to Emergency Dept:	☐ Yes	☐ No	Date:	Time	AM / PM
♦ Inform/Referred to Other Agency:	☐ Yes	☐ No	Date:	Time:	AM / PM
♦ Family (specify relationship):	☐ Yes	☐ No	Date:	Time:	AM / PM
♦ Workplace (specify):	☐ Yes	☐ No	Date:	Time:	AM / PM

8. Document name, telephone and I.D. number (e.g., Police I.D./badge #) of officials notified and names and contact information of potential victims or group:

9. Document history, risk factors, and measures taken to reduce risk. Outline safety plan.

PROGRESS NOTES: **Date:**

No Show:	❑ **Called Client**
Late Cancellation:	❑ **Informed Call Centre**

Session 1: **Relevant psychosocial information/Brief history of presenting problem:**

A. Goal(s):

B. Actions to support goal(s):

C. Next steps/homework:

D. Was this session helpful? 0 1 2 3 4 5 6 7 8 9 10
Not at all Somewhat Completely

E. Progress toward goal: 0 1 2 3 4 5 6 7 8 9 10
None at all Somewhat Complete

F. What could help the next session go better?

Client initials: **Counsellor signature & credentials**:

Pre-session contact (with client or other): **Date:**

Consultation with Clinical Supervisor/Manager (if applicable): **Date:**

Counsellor signature & credentials:

Session # **Date:**

No Show:	❑ **Complete sections A. and C.**
Late Cancellation:	❑ **Complete sections A. and C.**

A. Review of goal(s):

B. Actions to support goal(s):

C. Next steps/homework:

D. Was this session helpful? 0 1 2 3 4 5 6 7 8 9 10

Not at all Somewhat Completely

E. Progress toward goal: 0 1 2 3 4 5 6 7 8 9 10

None at all Somewhat Complete

F. What could help the next session go better?

Client initials: **Counsellor signature and credentials:**

Inter-session contact (with client, community resources, treating physician, etc.)

Date:

Consultation with Clinical Supervisor/Manager (if applicable): **Date:**

Counsellor signature and credentials:

Session # **Date:**

No Show:	❑ **Complete Sections A. and C.**
Late Cancellation:	❑ **Complete Sections A. and C.**

A. Review of goal(s):

B. Actions to support goal(s):

C. Next steps/homework:

D. Was this session

helpful? 0 1 2 3 4 5 6 7 8 9 10

Not at all Somewhat Completely

E. Progress toward goal: 0 1 2 3 4 5 6 7 8 9 10

None at all Somewhat Complete

F. What could help the next session go better?

Client initials: **Counsellor signature and credentials:**

Inter-session contact (with client, community resources, treating physician, etc.)

Date:

Consultation with Clinical Supervisor/Manager (if applicable): **Date:**

Counsellor signature and credentials:

Session # **Date:**

No Show:	❑ **Complete Sections A. and C.**
Late Cancellation:	❑ **Complete Sections A. and C.**

A. Review of goal(s):

B. Actions to support goal(s):

C. Next steps/homework:

D. Was this session helpful? 0 1 2 3 4 5 6 7 8 9 10
Not at all Somewhat Completely

E. Progress toward goal: 0 1 2 3 4 5 6 7 8 9 10
None at all Somewhat Complete

F. What could help the next session go better?

Client initials: **Counsellor signature and credentials:**

Inter-session contact (with client, community resources, treating physician, etc.)

Date:

Consultation with Clinical Supervisor/Manager (if applicable): **Date:**

Counsellor signature and credentials:

Session # **Date:**

No Show:	❑ **Complete Sections A. and C.**
Late Cancellation:	❑ **Complete Sections A. and C.**

A. Review of goal(s):

B. Actions to support goal(s):

C. Next steps/homework:

D. Was this session helpful?	0	1	2	3	4	5	6	7	8	9	10
	Not at all				Somewhat						Completely
E. Progress toward goal:	0	1	2	3	4	5	6	7	8	9	10
	None at all				Somewhat						Complete

F. What could help the next session go better?

Client initials: **Counsellor signature and credentials:**

Inter-session contact (with client, community resources, treating physician, etc.)

Date:

Consultation with Clinical Supervisor/Manager (if applicable): **Date:**

Counsellor signature and credentials:

Global Facesheet

Counsellor ID ____ **Activity Number** ____

Counsellor Name: ____

First Offered Appt: ___________ (dd/mm/yr) **First Scheduled Appt:** __________ (dd/mm/yr) **Closure Date:** _________ (dd/mm/yr) **Attended First Appt:** Yes ☐ No ☐

MDI Score (client): **MDI Score (second client):** **If MDI score NOT ENTERED please select one of the following reasons:**
☐ Client < 18 ☐ Client Declined ☐ Counsellor did not administer

Presenting Issues Categories *Mark one Primary and as needed, one Secondary selection*	**Presenting Issues** (mark only one selection per category)	**Goal Attainment and Resolution at Closure**
Addiction Related ☐ Prim ☐ Sec	☐ Alcohol ☐ Smoking ☐ Drug ☐ Addiction Other ☐ Gambling ☐ Other's Addiction	☐ Y ☐ N ☐ Partly
Abuse ☐ Prim ☐ Sec	☐ Verbal Abuse ☐ Emotional Abuse ☐ Childhood Abuse ☐ Physical Abuse ☐ Elder Abuse ☐ Sexual Abuse ☐ Domestic Abuse ☐ Child Abuse	☐ Y ☐ N ☐ Partly
Couple Relationship ☐ Prim ☐ Sec	☐ Communication/Conflict Resolution ☐ Relationship breakdown ☐ Intimacy issues ☐ Separation/Divorce ☐ Domestic violence ☐ Family planning ☐ Partner remained in home country ☐ Spouse Unable to work ☐ Relationship-General	☐ Y ☐ N ☐ Partly
Family ☐ Prim ☐ Sec	☐ Adolescent behaviour ☐ Blended family ☐ Communication ☐ Elder related ☐ Extended family relations ☐ Parenting ☐ Adjustment issues/culture shock ☐ Family Member Left Behind ☐ Family planning ☐ Child behavioiur	☐ Y ☐ N ☐ Partly
Personal Emotional ☐ Prim ☐ Sec	☐ Problem Obtaining prescription drugs ☐ Isolation ☐ Self-esteem ☐ Adjustment issues/ Culture shock ☐ Anger issues ☐ Depression ☐ Cross culture issues ☐ Social isolation ☐ Grief ☐ Mental Health Condition ☐ Life stages ☐ Repat issues ☐ Suicidal risk ☐ Sexuality ☐ Post trauma ☐ Eating disorder ☐ Self harm ☐ Anxiety ☐ Other	☐ Y ☐ N ☐ Partly
Stress ☐ Prim ☐ Sec	☐ Financial Stress ☐ Legal Stress ☐ Medical Stress ☐ Personal Stress	☐ Y ☐ N ☐ Partly
Work Related ☐ Prim ☐ Sec	☐ Cross Cultural Issues ☐ Work Performance ☐ Conflict (ie) Host National/ Management ☐ Work Relationship Conflict ☐ Language Barrier ☐ Workplace Stress ☐ Workplace Violence/ Harassment	☐ Y ☐ N ☐ Partly

Evaluation Summary

☐ **Client is still High Risk**		
☐ **Client returned home prematurely due to:**	☐ Problems Partially Solved ☐ Trauma in the Host Country ☐ Home country ☐ All Problems Solved/Treatment Complete ☐ Inability to adjust	☐ Project Terminated ☐ Client Terminated/Problems Not Solved ☐ Severe Health Issues ☐ Client/Employee at Risk for Premature Return ☐ Family Member at Risk for Premature Return
☐ **Client returned home temporarily due to:**	☐ Client/Family no Longer at Risk for Premature Return ☐ Illness/Injury	☐ Required Clinical Consultation ☐ Residential Treatment (drugs or alcohol) ☐ Family Emergency
☐ **Other**		

Closure and Referral

☐ EAP Goals Met ☐ Case Transferred ☐ Client Discontinued with EAP ☐ EAP Counsellor Withdrew (with Clinical Supervisor/Manager approval)

Client Referred Out of EAP? ☐ Y ☐ N (If 'Y' please fill out the section below)

Did the Client Accept the Referral? ☐ Y ☐ N Did the Client Use Referral? ☐ Y ☐ N ☐ Unknown

Referral Type: ☐ Addiction Services ☐ Hospital ☐ Community Resources ☐ Psychiatric ☐ Family Physician
☐ Specialized Counselling ☐ Group Support

Counsellor Signature and Credentials: ____ Date: ____

FILE CLOSURE

Any additional services required? ☐ Yes ☐ No

Resource(s): **Date of Appointment:**

Follow up calls:

1st attempt: Date: Time: AM / PM

2nd attempt: Date: Time: AM / PM

Follow up summary:

Clinical File Submission Checklist:

***Statement of Understanding*:**

☐ Signed or verbal agreement

☐ Not signed. Reason :

Satisfaction Survey given to client:

☐ Yes ☐ No Reason:

Risk Assessment completed:

☐ Yes ☐ No Reason:

Pre/post Assessment completed:

☐ Yes ☐ No Reason:

Facesheet completed:

☐ Yes ☐ No Reason:

Invoice completed (except for Staff counsellors):

☐ Yes ☐ No Reason:

Counsellor signature and credentials:

Counsellor Name:

Counsellor ID:

CLINICAL FILE

Service **Organization code** **Activity number**

Counsellor Status ***S*** ☐ ***P*** ☐ ***A*** ☐