

Extension Request		
To: Assure Programs	Fax No: Email:	1800 329 327 (1800 FAX EAP) info@assureprograms.com.au
Contact Information:		
Date of Request:  /    Psychologist's Name:    Client's Name:    Client's Organisation:	Date Required: Case # (if known): Client DOB:	/ / / /
Details of Request:		
Current entitlement sessions used		
Additional sessions requested		
Total entitlement		
Is the concern work related?   YES  NO Nature of primary concern:		
What will be achieved within the additional time, especially regarding maintaining the client at work (or returning to work)?		
Will the client be referred to another service? INO YES (if yes, provide further details below)		
Is this a rehabilitation case?	no' expected RTW date: /es' contact name: ntact number:	/ /
Client Consent:		
Import Most organisations are keen to gain some general understa issues underlying the need for extended EAP support. To ass the client's permission for the Assure EAP Psy Please complete <b>one</b> of the following consent options:	sist Assure to obtain an exte	ension, where possible could you please seek
Consent for the Assure EAP Psychologist to <u>discuss the work related issues without releasing the client's name.</u> Please request the client completes the below authorisation:		
I authorise the Assure EAP Psychologist to discuss my wor extension process, <u>without</u> releasing my name.	rk related issues with my or	ganisational EAP contact as part of the
Client Name:		
Client Signature:	Date:	/
OR		
Consent for the Assure EAP psychologist to release the clip Please request the client completes the below authorisation:	ient's name to the organis	sation and discuss the work related issues.
I authorise the Assure EAP Psychologist to discuss my wor extension process, <u>including</u> the release of my name.	rk-related issues with my or	ganisational EAP contact as part of the
Client Name:		
Client Signature:	Date:	/ /

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Ph: 1800 808 374
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