FaxBack Referral Form please fax to 506-672-2619

Name of Employee_____

Do you wish the SAP to contact the employee? Yes No (please circle)

Phone Numbers (if known)

_____

Address if known: (the general area)

_____

_____

Status of Employee: suspended, laid off, working, pre employment (please circle)

Company _____

Incident which prompted Substance Abuse Assessment (if drug test please give date and substance)

_____

_____

_____

_____

Name and address of contact person for report and billing.

_____

_____

_____

Is the employee responsible for payment? Yes No (please circle)

Would you like a faxed, E-mail or mailed report? (Please circle)

Do you require the SAP to travel to the employee? Yes, No (please circle)

Any special instructions or information you would like to add to aid with the assessment?

_____

_____

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