

Integrated Health Home

Referral Form

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| **Referral Contact Information**  |
| Referral initiated by:    |    |
| Email:  |    |
| Phone:   |    |
| Date of referral:  |   |

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| **Client Information**  |
| Client Name:  |    |
| Date of Birth:  |    |
| Parent/Guardian, if Applicable |  |
| Client Address:  |    |
| Client Phone Number:  |    |
| MCO/Client ID Number:  |   |

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| **Current Providers**  |
| Primary Care Physician:  |   |
| Behavioral Health Provider(s):  |   |
| Other Providers:   |   |

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| ***Please check if the individual has difficulties that substantially interfere with or limit the achievement of or maintaining skills in the following areas:***  * Social
* Behavioral
* Cognitive
* Work/School
* Community
* Family
* Communicative or Adaptive Skills
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| ***Please describe the frequency, intensity, and duration of impairment. Include what areas of the individual’s life are being directly affected by these and how. Attach additional pages if necessary.***  |
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Records documenting a current (within the past 12 months) diagnosis of a Serious Mental Illness is required to enroll in our program. Please fax this completed referral form, a release of information, and any mental health records to (515) 598-7452 or email to IHH@steppingstoneia.com