

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 |
| ***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](mailto:IHH@steppingstoneia.com)