Integrated Health Home
Referral Form

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

Client Information	
Client Name:	
Date of Birth:	
Client Address:	
Client Phone Number:	
MCO/Client ID Number:	

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

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.

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