REFERRAL FOR SERVICES

(FAX TO APPROPRIATE LOCAL BRANCH OFFICE):

ARENAC:	**989-846-0431**	**CLARE:**	**989-539-4449**	**GLADWIN:**	**989-426-6952**
ISABELLA:	**989-773-4319**	**OSCEOLA:**	**231-832-1020**	**ROSCOMMON:**	**989-366-8921**

MIHP – Maternal Infant Health Program

Central Michigan District Health Department
Promoting Healthy Families, Healthy Communities

Date of Referral: _____Referring Physician/Office _____

Phone: _____ Fax: _____ Contact Name: _____

Patient Information: Fill out Applicable Information per Patient

Name: _____ DOB _____ EDC _____

Address _____ City _____Zip _____

Phone _____ Parent/Guardian Name: _____

Reason for Referral: INFANT

- ❑ Health Issues
- ❑ Safety
- ❑ Feeding/Nutrition
- ❑ Prematurity/LBW
- ❑ Growth/Development
- ❑ Family Issues
- ❑ Social Support/Parenting
- ❑ Other _____

Reason for Referral: MATERNAL

- ❑ Inadequate Prenatal Care
- ❑ Social Support Deficit
- ❑ Family Planning
- ❑ Smoking/Alcohol/Drug Use
- ❑ Food/Housing Issues
- ❑ Transportation Needs
- ❑ Stress/Depression/MH
- ❑ Abuse/Violence
- ❑ Other_____

- ❑ Patient/Parent/guardian has signed a release authorizing this sharing of protected health information.
- ❑ Patient/Parent/guardian is aware of this referral to the MIHP.
- ❑ Patient has active Medicaid coverage (only Medicaid covers MIHP services at this time)

LHD Use Only:

❑ **DATE patient/parent/guardian contacted regarding MIHP services:** _____

Outcome of Referral:

- ❑ Enrolled
- ❑ Refused program
- ❑ Unable to locate
- ❑ Other _____

_____/_____
Signature of MIHP Professional Staff *Date*