

# 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**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Health Issues            | <input type="checkbox"/> Safety             | <input type="checkbox"/> Feeding/Nutrition |
| <input type="checkbox"/> Prematurity/LBW          | <input type="checkbox"/> Growth/Development | <input type="checkbox"/> Family Issues     |
| <input type="checkbox"/> Social Support/Parenting | <input type="checkbox"/> Other _____        |  |

### **Reason for Referral: MATERNAL**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Inadequate Prenatal Care | <input type="checkbox"/> Social Support Deficit | <input type="checkbox"/> Family Planning      |
| <input type="checkbox"/> Smoking/Alcohol/Drug Use | <input type="checkbox"/> Food/Housing Issues    | <input type="checkbox"/> Transportation Needs |
| <input type="checkbox"/> Stress/Depression/MH     | <input type="checkbox"/> Abuse/Violence         | <input type="checkbox"/> 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*

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