Maternal Infant Health Program
and Children Special Health Care Services

Referral Form

Referral Date	Referred By (Name, Phone, Organization)		Language Preference
Infant's Birthdate	Infant's Name Boy___Girl___	Primary Medical Provider and Phone Number	
Mother's Birthdate	Mother's Name	Primary Medical Provider and Phone Number	

Weeks Gestation_________

Family address and Phone

Street Address (and Apartment Number)	City/State/Zip	County
Cell	Phone	Email Address (Text or Email Preferred)

*Contact Preference: Text or Call

	Yes	No
Does the mother have any form of Medicaid, Healthy MI Plan or is uninsured and agrees to services?		
Was the Infant referred to a pediatric medical specialist? **If Yes, specialist's name:** ____________________ Specialist phone number: ____________________	Yes	No

Other comments or concerns?

I hereby give permission to the hospital to share the above information with the Ottawa County Department of Public Health Maternal Infant Health Program and Children's Special Health Care Services to aid in receiving early childhood services for my child and me.

Parent/Guardian Signature ______________________________ Date ______________

If yes is checked on any question, please fax this form to (616)393-5620.
Please call (616)393-5731, if you have any questions.

miOttawa Department of Public Health