

## Maternal Infant Health Program (MIHP) Referral



Client Na	ame:	DOB:	Medicaid #:	
Address	:			
Phone #: Medic		dical Provider: _		
If Maternal Referral:				
G:	P:	EDC	:	
If Infant Referral:				
Birth Weight: Length:			Gestation Age:	
Guardian/Parent Name: DOB:			DOB:	
Check all that apply:				
	No or limited supports			
	Homeless or housing concerns			
	Language/Cultural Barrier (specify):			
	Transportation concerns			
	Smoking			
	Mother with cognitive, emotional or mental illness (low functioning mother) (specify):			
	Family history of abuse or neglect			
	History of fetal or neonatal loss			
	Low birth weight (less than 2500 grams)			
	Failure to thrive			
	Exposure to alcohol or drugs-parental use during pregnancy (specify):			
Comments:				
I understand that I will be contacted by a member of the MIHP team to set up an appointment.				
Client or G	uardian Signature		Date	
Referring Staff Agency		ncy	Date	