



Maternal Child Health Referral

Form completed by:		DATE:		Case #	
Referral source:			Phone		
Client aware of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No			Comment		
CLIENT/PATIENT CONTACT INFORMATION					
Name				<input type="checkbox"/> M <input type="checkbox"/> F	DOB
Race (Check all that apply)		<input type="checkbox"/> Caucasian	<input type="checkbox"/> African American	<input type="checkbox"/> Asian	<input type="checkbox"/> Native American
<input type="checkbox"/> Hispanic/Latino		<input type="checkbox"/> Unknown		<input type="checkbox"/> Refused	
Interpreter Needed		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Language:	
Address			Apt #	City	Zip
Phone		Will Accept Texts <input type="checkbox"/> Y <input type="checkbox"/> N			Email
Alt Phone		Will Accept Texts <input type="checkbox"/> Y <input type="checkbox"/> N			
Additional Contact Name				Phone	
<input type="checkbox"/> Infant/Child's Father		<input type="checkbox"/> Spouse		<input type="checkbox"/> Partner	<input type="checkbox"/> Minor's Guardian
CLIENT/PATIENT MEDICAL INFORMATION					
Medical Provider				Phone	
Health Insurance:		<input type="checkbox"/> Medicaid	<input type="checkbox"/> Commercial/Private	<input type="checkbox"/> None	<input type="checkbox"/> Unknown
Maternal History:		EDC (Due Date)	Gravida (# of Pregnancies)	Para (# of Deliveries)	
Preterm Delivery <input type="checkbox"/> Y <input type="checkbox"/> N		Low Birth Weight <input type="checkbox"/> Y <input type="checkbox"/> N	Miscarriage <input type="checkbox"/> Y <input type="checkbox"/> N	Infant Loss <input type="checkbox"/> Y <input type="checkbox"/> N	
INFANT/CHILD INFORMATION					
Infant /Child	Name		DOB	<input type="checkbox"/> M <input type="checkbox"/> F	Birth Weight
					Current Weight
Medical Provider:					Phone:
IDENTIFIED ISSUES					
<input type="checkbox"/> Housing Information		<input type="checkbox"/> Transportation Challenges		<input type="checkbox"/> Tangible Needs	<input type="checkbox"/> Nutrition/Food Resources
<input type="checkbox"/> Maternal Depression	<input type="checkbox"/> Current <input type="checkbox"/> History	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Current <input type="checkbox"/> History	<input type="checkbox"/> Tobacco	<input type="checkbox"/> Current <input type="checkbox"/> History
<input type="checkbox"/> Mental Health Diagnosis:	<input type="checkbox"/> Current <input type="checkbox"/> History	<input type="checkbox"/> Drugs:	<input type="checkbox"/> Current <input type="checkbox"/> History	<input type="checkbox"/> Chronic Disease:	<input type="checkbox"/> Current <input type="checkbox"/> History
Please explain circumstances, above risks, and any other risks or concerns.					
Results of Referral (office use only)					
Date form returned to referral source		Program Assigned		Staff Assigned	
<input type="checkbox"/> Open to Services		<input type="checkbox"/> Refused Services		<input type="checkbox"/> Unable to locate	
<input type="checkbox"/> Referred to Another Program/ Service:				<input type="checkbox"/> Other	

5303 S. Cedar, P.O. Box 30161, Lansing, MI 48909
Phone (517) 887-4322 Fax: (517) 887-4384

Revised 10.2015