DISTRICT HEALTH DEPARTMENT NO. 2
Maternal Infant Health Program

630 Progress Street, West Branch, MI 48661
Phone (800) 504-2650 x 1826 Fax (989) 343-1899

Please fill out the following information, as applicable, for Mother or Infant referral. Fax or mail to District Health Department No. 2.

Date: _____

Mother's Name: _____ Age: _____ Marital Status: S M D Sep W

Infant's Name: _____ Gender: _____ DOB: _____

EDC: _____ Primary Medical Provider: _____

Address: _____ City: _____

Home Phone: _____ Cell Phone: _____ Alt. Phone: _____

Medicaid: _____Yes _____No Enrolled in HMO? _____

Mother's History: G____P____M____A____ Hgb: _____ Weight: _____ Blood Pressure: _____

# of Prenatal Visits: _____ Type of Delivery: _____

Medical Risks: _____

Infant History: Birth Weight: _____lbs _____oz Birth Length _____ Head Circ _____ Apgars _____/_____

Gestational Age: _____ Any complications: _____

Mother/Infant Interaction: ____ Appropriate _____ Concerns: _____

_____

Referrals Requested: _____WIC _____ Immunizations _____Maternal Infant Health Program

_____ Family Planning _____ Children's Special Health Care Services _____Other: _____

I hereby authorize _____ to release the above information to District Health Department No. 2.

_____ _____
Signature of Parent/Guardian Date Signature for Referring Agency Date

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Results of Referral: _____

Signature of Staff/Date: _____