Washtenaw County
Health Department

Maternal Infant Health Program (MIHP)
Referral

Maternal Referral (pregnant woman with Medicaid insurance):

Client Name: _____ DOB: _____

Medicaid #: _____ Primary Language: _____

Address: _____

Phone #: _____ Medical Provider: _____

EDC: _____ Number of Pregnancies: _____ Number of Live Births: _____

Infant Referral (newborn to 11 months old with Medicaid insurance):

Client Name: _____ DOB: _____

Birth Weight: _____ Length: _____ Gestation Age: _____

Medicaid #: _____ Medical Provider: _____

Guardian/Parent name: _____ DOB: _____

Address: _____

Phone #: _____ Primary Language: _____

Comments/Concerns:

☐ **I agree to have a MIHP team member contact me to set up an appointment.**

Referring Staff | Agency | Phone Number | Date

Please fax referral to Lisa Stoll at (734) 544-9738. Thank you! **1/2018**