

**REQUIRED SECTION**

Parent/Guardian's Name:	Parent/Guardian's Date of Birth:
Child's Name:	Due Date/Child's Date of Birth:
Address:  City: _____ State: _____ Zip: _____ Please check the patient's preferred method of contact __Phone: _____ __Text: _____ __Email: _____	Is the patient a first time parent? __YES or __NO  Is the parent or child a Tribal Member or person of American Indian/Alaska Native decent? __YES or __NO
Check any home visiting programs in which the patient is <b>currently enrolled</b> . __Maternal Infant Health Program (MIHP) __Early Head Start __Healthy Families UP __Parents as Teachers __Family Spirit __Other (please specify): _____	Currently enrolled in WIC? __YES or __NO  Current Health Insurance Coverage? __Medicaid __Private __None
Notes and Special Instructions:    	

**OPTIONAL SECTION**

<u>Infant/Child</u>  Birth Length _____ cm. Birth Weight: _____ gm. Head Circumference: _____ in Current Height _____ cm. Current Weight: _____ gm. Date taken: _____ Hemoglobin: _____ Date Taken: _____ Weeks Gestation: _____
<u>Pregnant/Postpartum Women</u>  Height: _____ cm. Weight: _____ gm. Date taken: _____ Breastfeeding (or planning to): __YES or __NO Hemoglobin: _____ Date taken: _____ Date of 1st Prenatal visit: _____ Pre-Pregnancy Weight: _____ gm. Weight at Last Prenatal Visit: _____ gm.

**SIGNATURES**

I understand that this information may be shared with agencies who provide home visiting services, as well as my local Health Department WIC office, so they can contact me with information to help connect me to local services. Signing this form does not guarantee services. I understand that not all services may be available in my area.	
Parent/Guardian Signature: _____	Date: _____
Referring organization/agency: _____	
Referring Agency Signature: _____	Date: _____

# Referring Agency Instructions

Submit this referral form to the services coordination hub serving your county.

## **Marquette County:**

Please fax or securely email completed form to:

Marquette County Health Department  
Attn: Maternal Child Coordinator  
Fax: 906-475-4435  
Email: [sengstrom@mqtco.com](mailto:sengstrom@mqtco.com)  
Phone: 906-315-2631

## **Alger, Delta, Dickinson, Iron, Luce, Mackinac, Menominee, and Schoolcraft Counties:**

Please fax or securely email completed form to:

LMAS District Health Department  
Attn: MIHP Coordinator  
Fax: 906-341-5230  
Email: [lespinoza@lmasdhd.org](mailto:lespinoza@lmasdhd.org)  
Phone: 906-324-6951 x125

## **Baraga, Gogebic, Houghton, Keweenaw, and Ontonagon Counties:**

Please fax or securely email completed form to:

Western UP Health Department  
Attn: MIHP Coordinator  
Fax: 906-482-9410  
Email: [sverville@wuphd.org](mailto:sverville@wuphd.org)  
Phone: 906-482-7382 x183 | 906-231-6019

## **Chippewa County:**

Please fax or securely email completed form to:

Chippewa County Health Department  
Attn: MIHP Coordinator  
Fax: (906) 635-7081  
Email: [czimmerman@chippewahd.com](mailto:czimmerman@chippewahd.com)  
Phone: (906) 635-3577