



PLEASE FAX REFERRAL  
TO BRIDGET HUSS AT  
**(734) 240-7838**

# MATERNAL INFANT HEALTH PROGRAM (MIHP) REFERRAL FORM

2353 S. Custer Monroe, MI 48161  
Phone: 734-240-7886  
Fax: 734-240-7838

**Maternal Referral (pregnant woman with Medicaid insurance):**

Client Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Medicaid #: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

Phone #: \_\_\_\_\_ EDC: \_\_\_\_\_

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

Client Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Gender: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Medicaid #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

**Referring Agency Contact Information:**

Referring Agency

Phone #

Referring Staff (Please print)

Date

Comments/Concerns:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_