Ingham County Health Department

Public Health Services Referral

Form completed by:	**DATE:**	Case #
Referral source:	Phone	
Client aware of referral? ☐Yes ☐No	Comment	

CLIENT/PATIENT CONTACT INFORMATION

Name	☐**M** ☐**F**	**DOB**

Race (Check all that apply)	☐ Caucasian	☐ African American	☐ Asian	☐ Native American
☐ Hispanic/Latino	☐ Unknown		☐ Refused	

Interpreter Needed	☐ Yes	☐ No	Language:

Address	**Apt #**	**City**	**Zip**
Phone	Will Accept Texts ☐ Y ☐ N	**Email**	
Alt Phone	Will Accept Texts ☐ Y ☐ N		

Additional Contact Name	**Phone**

☐Infant/Child's Father	☐Spouse	☐Partner	☐ Minor's Guardian

CLIENT/PATIENT MEDICAL INFORMATION

Medical Provider	**Phone**

Health Insurance:	☐ Medicaid	☐ Commercial/Private	☐ None	☐ Unknown
Maternal History:	EDC (Due Date)	Gravida (# of Pregnancies)	Para (# of Deliveries)	
Preterm Delivery ☐ Y ☐ N	Low Birth Weight ☐ Y ☐ N	Miscarriage ☐ Y ☐ N	Infant Loss ☐ Y ☐ N	

INFANT/CHILD INFORMATION

Infant /Child	Name	DOB	☐M ☐F	Birth Weight	Current Weight
Medical Provider:				Phone:	

IDENTIFIED ISSUES

☐ Housing Information	☐ Transportation Challenges	☐ Tangible Needs	☐ Nutrition/Food Resources

☐ **Maternal Depression**	☐ Current ☐ History	☐ **Alcohol**	☐ Current ☐ History	☐ **Tobacco**	☐ Current ☐ History
☐ **Mental Health Diagnosis:** _____	☐ Current ☐ History	☐ **Drugs:** _____	☐ Current ☐ History	☐ **Chronic Disease:** _____	☐ Current ☐ 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
☐ Open to Services	☐ Refused Services	☐Unable to locate
☐ Referred to Another Program/ Service:		☐Other

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