# http://www.ewashtenaw.org/government/departments/cmhpsm/cmhpsm_home/cmhpsm_monroelogo.jpg

# Parent- Infant Program Referral Form

## Parent Information

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| --- |
| In order to be eligible, mom has to be pregnant or have a child age 3 or under.  |
| Mother & Father’s Full Name: |  |
| Address: |  |
| Phone No: |  |
| DOB: |  |

|  |
| --- |
| Insurance Information (Please Check One or More):  🗖 No Insurance 🗖 Medicaid 🗖 Private Insurance 🗖 Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

## Family Information (include all children in the home)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | DOB | Age | **Relationship** | **In foster care? (y/n)** |
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## Reason for Referral

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## Notable Areas of Need (check all that apply)

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| --- | --- | --- |
| 🗖 Parental Cognitive Impairment | 🗖 History of Postpartum Depression | 🗖 History of Suicidal Ideation/Attempt |
| 🗖 Teen Mom | 🗖 History of Substance Use | 🗖 History of Mental Health Treatment |
| 🗖 Problems Feeding Infant | 🗖 Current Substance Use | 🗖 History of Domestic Violence |
| 🗖 Parental Medical Issues | 🗖 Recent death of natural support | 🗖 Strong negative feeling about child |
| 🗖 Survivor of Rape | 🗖 Unresolved grief issues | 🗖 Inadequate housing/material resources |
| 🗖 Perception that infant/toddler is inconsolable | 🗖 Child with Special Needs (i.e. Autism, developmental delays) | 🗖 History of CPS involvement |
| 🗖 Receives SSI/SSDI | 🗖 No GED/High School Diploma | 🗖 Current CPS involvement |

## Referral Source Info

|  |  |  |  |
| --- | --- | --- | --- |
| **Referral Agency:**  |  |  |  |
| **Referring Worker/Date:**  |  |  |  |
| **Referral Source Phone Number:** |  |  |  |

|  |
| --- |
| **Please sign below if you agree that Monroe Community Mental Health Authority (MCMHA) can contact you to discuss Infant Mental Health services at our agency. By signing below you also agree that if MCMHA is unable to get into contact with you, MCMHA will follow up with the worker who made the referral for Infant Mental Health Services to determine if you continue to be interested in the service.** |
| **Parent’s Printed Name:**  |  |  |  |
| **Parent’s Signature/Date:**  |  |  |  |

## Submission Information

To submit, please **fax, mail or deliver this form to**:

**Kathleen Moore OR** **Geralyn Harris**

Program Supervisor Clinical Director

Phone: 734-384-0351 Phone: 734-384-8761

Monroe Community Mental Health Authority

1001 S. Raisinville

Monroe, MI 48161

Fax: 734-243-5564

## MCMHA Use Only

|  |  |  |  |
| --- | --- | --- | --- |
| **Date Received:**  |  |  **Date Contacted:** |  |
| **Opened?:** |  |  **If no, why not?** |  |