GROWING STRONG
MIHOW®
Maternal Infant Health Outreach Worker

MIHOW REFERRAL FORM

Name_____
Address_____
_____
Phone_____Message Phone_____
Participant mom's age_____ School _____ Grade _____
Directions to home_____
_____
_____

Type of referral: Prenatal-Due Date_____Infant Birthdate_____

Reasons for referral:_____
_____
_____

Any safety issues Home Visitor should be aware of:_____
_____

Referred to MIHOW by: Name_____
Agency_____

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Referred by:_____Date_____

Assigned to:_____Date_____

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Services received: (To be completed by Home Visitor when mother is exited)
No. prenatal visits_____No. postnatal visits_____
No. referrals made_____Exit date_____

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Please send referrals to: Debbie Withrow, MIHOW Site Leader
19 Raven Street
Fayetteville, WV 25840
(304) 469-2415 (phone & fax)
debbiewithrow@suddenlink.net

Or contact: Kathy Bracken, MIHOW Coordinator
(304) 574-3772 (home) or (304) 663-7117 (cell)
kathy.mihow@gmail.com

DW/February 2014