Families Together of Orange County

Plan of Safe Care

Prenatal Collaboration

Mother's Information	Pregnancy Information
Name: **DOB:**	**Weeks Pregnant:** **Delivery Date:**
Address: **Phone Number:** **Emergency Contact:** Name: Relationship: Phone Number:	**OBGYN Name:** Facility: Phone Number: Address: **PCP Name:** Facility: Phone Number: Address:

Identified Supports	Name	Contact Information	Role
☐ Spouse/Partner			
☐ Family			
☐ Friends			
☐ Counselor			
☐ Spiritual/Faith Community			
☐ Recovery Community			
☐ Secondary Caregiver			
☐ Peer Mentor			

Mental/Behavioral Health	
Provider Facility:	**Provider Name:**
Address:	**Number:**
Screening & Date	**Score**
☐ PHQ-9	
☐ GAD-7	
☐ SBIRT	
☐ Family Needs Assessment	
☐ ACEs	

Parent/Caregiver's Referrals	Resource Information
☐ MAT	☐ MOMs OC
☐ Substance Use Outpatient	☐ CPSP
☐ Substance Use Testing	☐ Healthy Steps
☐ 12 Step Program	☐ Other:

Hospital Collaboration

Delivery Information	
Hospital Name: Hospital Address:	Hospital Record Number: Completed By:
CWS/CMS Staff Name: Staff Phone Number: Referral or Case Number:	Case Opened On: Case Status:
Infant Name:	Delivery Date:

Release of Information	
☐ Completed on: _____	☐ Declined: _____
Client Signature:	

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Mother's Information	Infant's Information
Mark all substances reportedly used during pregnancy: ☐ Alcohol ☐ Amphetamine ☐ Barbiturates ☐ Benzodiazepines ☐ Cannabinoids (Marijuana) ☐ Cocaine ☐ Codeine ☐ Crack Cocaine ☐ Ecstasy ☐ Fentanyl ☐ Heroin ☐ Hydrocodone (Vicodin) ☐ Methadone ☐ Methamphetamine ☐ Opiates ☐ Oxycodone ☐ Xanax ☐ Other Drug:_____ Positive Urine Screen ☐ Yes ☐ No Confirmed Toxicology Screen ☐ Yes ☐ No *If "Yes," list substance(s):* Date mother last used: **Comments:**	Positive Screen Blood ☐ Yes ☐ No Meconium ☐ Yes ☐ No Urine ☐ Yes ☐ No Confirmed Screen Blood ☐ Yes ☐ No Meconium ☐ Yes ☐ No Urine ☐ Yes ☐ No Confirmed Screen Pending ☐ Yes ☐ No Withdrawal Symptoms ☐ Yes ☐ No *Check applicable symptoms below:* ☐ High pitched cry ☐ Sleep disturbance ☐ Tremors ☐ Respiratory issues ☐ Poor feeding ☐ Vomiting ☐ Loose stools ☐ Increased muscle tone Finnegan/NAS Score:_____ Was a Fetal Alcohol Syndrome (FAS) Screening conducted? ☐ Yes ☐ No FAS Screening Result: ☐ Yes ☐ No ☐ Unk **Comments:**

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Parent/Caregiver's Treatment	Infant's Treatment
☐ MAT ☐ Substance Use Outpatient ☐ Substance Use Testing ☐ 12 Step Program ☐ Mental/Behavioral Health ☐ CPSP ☐ Healthy Steps ☐ Other: _____ _____ **Comments:**	☐ Medication for withdrawal symptoms List medications: ☐ Developmental Needs: ☐ Other Medical Conditions: **Comments:**

Resources/Referrals for Parent *(Provide the name & contact info of the resource/referral given)*	**Resources/Referrals for Infant** *(Provide the name & contact info of the resource/referral given)*
☐ Counseling Provider:	☐ Information of Infant's Primary Care Physician: Name: Phone#:
☐ Substance Use Outpatient Program:	
☐ Substance Use Testing Location:	☐ Public Health Nursing Home Visitation:
☐ 12 Step Program Location(s)	
☐ Family Resources Center (FRC):	☐ Women Infants Children (WIC) Program:
☐ Parenting Class:	
☐ Employment Training:	☐ Other:
☐ Financial Assistance:	
☐ Housing Assistance:	

☐ Basic Needs/Food/Transportation:	**Comments:**
☐ Other:	
Comments:	

Is the infant discharged in the care of someone other than the mother? ☐ **Yes** ☐ **No**

If "Yes,"

Name:		Relationship to Infant:	
Address:		Phone#:	

IN SIGNING THIS PLAN OF SAFE CARE, YOU ACKNOWLEDGE THAT:

- You received resources/referrals to address your infants' exposure to a substance/substances
- You received resources/referrals to address your substance abuse
- You received a copy of this Plan of Safe Care

Parent/Caregiver Print Name	Parent/Caregiver Signature	Date
Parent/Caregiver Print Name	Parent/Caregiver Signature	Date
Parent/Caregiver Phone#	Parent/Caregiver Phone#	
Provider/CPHW Print Name		
Provider/CPHW Phone#	Provider/CPHW Signature	Date