Orange County Children and Family Services

Plan of Safe Care—Collaboration with Hospital

For Substance Affected Infants

Hospital Name: ____________________ **Hospital Medical Record#:** ______________

Hospital Medical Record completed by: ____________________________________

CWS/CMS Referral or Case #: *(when applicable)* ____________________________________

Mother's Information	Infant's Information
Name: (Last, First)	**Name: (Last, First)** **DOB:**

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

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

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

Original: Parent/Caregiver
Copy: Child Services Acco
CWS/CMS: Child's Client Notebook

Confirmed Toxicology Screen ☐ Yes ☐ No *If "Yes," list substance(s):* ____________ ____________ Date mother last used: ____________ **Comments:**	Finnegan/NAS Score: _____ ☐ N/A Was a Fetal Alcohol Syndrome (FAS) Screening conducted? ☐ Yes ☐ No FAS Screening Result: ☐ Yes ☐ No ☐ Unk **Comments:**

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

Resources/Referrals for Parent *(Provide the name & contact information of the resource/referral given)*	Resources/Referrals for Infant *(Provide the name & contact information 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)	☐ Regional Center:
☐ Family Resources Center (FRC):	☐ Women Infants Children (WIC) Program:
☐ Parenting Class:	☐ Other:
☐ Employment Training:	
☐ Financial Assistance:	

Original: Parent/Caregiver
Copy: Child Services Acco
CWS/CMS: Child's Client Notebook

☐ Housing Assistance:	**Comments:**
☐ Basic Needs/Food/Transportation:	
☐ 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#	
Social Worker Print Name		
Social Worker Phone#	Social Worker Signature	Date

Reason parent/caregiver signature is absent:
☐ Whereabouts Unknown ☐ Incarcerated ☐ Refused/Declined ☐ Identify Unknown ☐ Other:

Original: Parent/Caregiver
Copy: Child Services Acco
CWS/CMS: Child's Client Notebook