|  |  |  |
| --- | --- | --- |
| **NAME OF** [**LOCAL DEPARTMENT**](http://www.dhr.state.md.us/blog/?page_id=3973) **BEING NOTIFIED**  | **ADDRESS**  | **ZIP** |
|       |       |       |
| **NAME OF PERSON MAKING REPORT**  | **POSITION/TITLE** | **SIGNATURE (*Required after printing*)** |
|       |       |  |
| **NAME OF HOSPITAL/BIRTHING CENTER** |  **ADDRESS** | **ZIP**  | **TELEPHONE** |
|       |       |       |       |

| **NAME OF NEWBORN**  | **DATE OF BIRTH(***The NEWBORN must be less than 30 days old)* | **WEIGHT(*Grams)*** | **GESTATIONAL AGE** |
| --- | --- | --- | --- |
|       | Click here to enter a date. |       |       |
| **ADDRESS WHERE NEWBORN CAN BE SEEN**  | **CITY** | **STATE** | **ZIP** | **GENDER**  | **RACE** |
|       |       |       |       |       |       |
| **PARENTS**  | **DOB** | **ADDRESS** | **TELEPHONE** |
| **MOTHER:** |       |       |       |       |
| **FATHER OF NEWBORN:**  |       |       |       |       |
| **ALTERNATE CAREGIVER:**  |       |       |       |       |
| **PRENATAL CARE** *(select one)* | **C-SECTION**  | **NICU**  | **ESTIMATED LENGTH OF STAY**       | **PLANNED DISCHARGE DATE**       |
| **MOTHER’S DRUG OF USE**  | **NEWBORN’S DRUG OF EXPOSURE** |
|       |       |
| **Referral Information (** *All sections must be completed by reporter to the extent known***)** |
| **NEWBORN’S MEDICAL CONDITION AND CURRENT AND/OR ONGOING HEALTH CONCERNS:** |
|  |       |
| **SYMPTOMS OF WITHDRAWAL FROM OR EFFECTS OF PRENATAL ALCOHOL OR CONTROLLED DRUG EXPOSURE ON THE NEWBORN:** |
|  |       |
| **IMPACT OF ALCOHOL OR CONTROLLED DRUG USE ON MOTHER’S ABILITY TO PROVIDE PROPER CARE AND ATTENTION TO NEWBORN:** |
|  |       |
| **NATURE AND EXTENT OF MOTHER’S CURRENT DRUG USE AND HISTORY OF PREVIOUS TREATMENT:** |
|  |        |
| **EXTENT TO WHICH MOTHER IS RESPONSIVE TO NEWBORN’S NEEDS AND IS INVOLVED WITH PROVIDING CARE:** |
|  |       |
| **NATURE AND EXTENT OF PARENTS’ SOCIAL SUPPORT SYSTEM:** |
|  |       |
| **EXTENT OR HISTORY OF ANY VIOLENCE, MENTAL ILLNESS, OR COGNITIVE LIMITATIONS:** |
|  |       |
| **NATURE AND EXTENT OF RISK OF HARM TO THE NEWBORN:** |
|  |       |
| **PARENTS’ LEVEL OF COOPERATION:** |
|  |       |
| **PREPARATIONS FOR NEWBORN:** |
|  |        |
| **ANY OTHER AVAILABLE INFORMATION THAT WOULD ASSIST STAFF IN ASSESSING SAFETY AND RISK AND DEVELOPING PLAN OF CARE:** |
|  |       |
| **INFORMATION ON PREVIOUS INVOLVEMENT WITH THE DEPARTMENT OF SOCIAL SERVICES** |
|  |       |
| **NAME OF LDSS STAFF PERSON TO WHOM REPORT MADE:** | **DATE /HOUR** |
|       | Click here to enter a date.**/** |