State of Maryland – In Home Services

NOTIFICATION OF SUBSTANCE-EXPOSED NEWBORN (SEN)

The completed form must be submitted as soon as reasonably possible and not later than 48 hours after the contact, examination, attention, treatment, or testing that prompted the notification to the local department of Social Services where the newborn's parent or caregiver intends to reside with the substance-exposed newborn. **This form does not exempt a reporter from making an oral notification to the Local Department of Social Services (LDSS) as Md. Code Ann. Fam. Law. § 5-704.2 requires a reporter to make an oral and a written notification to LDSS.** * = Required Field

Section I: SEN INFORMATION

*Name and Address of Local Department of Social Services (*LDSS*):
Choose an item

*Name of Person Making Report: *Position/Title: *Contact Number:

*Name of Hospital/Birthing Center: Choose an item

Section II: NEWBORN'S REFERRAL INFORMATION

a. *Name of Newborn: **b.** *Date of Birth *(the newborn must be less than 30 days old)* [*M/D/YYYY*]:

c. *Weight (*pounds and ounces in numeric form*): **d.** *Gestational Age (*type numeric form*):

e. ***Newborn's Substance Exposure** *select all that apply*:

Category - OPIOIDS ☐ Heroin/Schedule I ☐ Hydrocodone/Schedule II ☐ Buprenorphine/Schedule II ☐ Morphine/Schedule II
☐ Fentanyl/Schedule II ☐ Oxycodone/Schedule II ☐ Oxycodone-Percocet/Schedule II ☐ OxyContin/Schedule II ☐ Codeine/Schedule II
☐ Methadone/Schedule II **Category - STIMULANTS** ☐ Cocaine/Schedule II ☐ Methamphetamine/Schedule II
☐ Methylphenidate (Ritalin)/Schedule II ☐ Amphetamine/Schedule II ☐ *Adderall* ☐ *Vyvanse*
Category - DEPRESSANTS ☐ Benzodiazepine/Schedule IV ☐ *Valium* ☐ *Xanax* ☐ Barbiturates ☐ Alcohol
Category - HALLUCINOGENS and OTHER COMPOUNDS ☐ Marijuana/Schedule I ☐ Amphetamine/Schedule I- Ecstasy ☐ LSD/Schedule I
☐ Ketamine/Schedule III ☐ Phencyclidine (PCP)/Schedule II ☐ Other

e.1. Test administered to determine newborn's substance exposure: Other (specify)

Specify Other

f. *Newborn Affected by Substance Exposure: Choose an item

g. *Newborn Displays Effects of Fetal Alcohol Spectrum Disorder: Choose an item

h. *Newborn Withdrawal Symptoms Resulting From Prenatal Exposure: Choose an item

h.1. If yes, select all withdrawal symptoms present *select all that apply:*

☐ Tremors ☐ Irritability ☐ Excessive Crying ☐ Sleep Problems ☐ Sweating ☐ Sneezing ☐ Yawning
☐ Fever or Unstable Temperature(s) ☐ Excessive Weight Loss ☐ Rapid Breathing ☐ Nasal Stuffiness ☐ High Pitched Crying ☐ Seizures
☐ Hyperactive Reflexes ☐ Poor Feeding ☐ Excessive Sucking ☐ Vomiting ☐ Rapid Heart Rate ☐ Other

Specify Other

i. *Medication Treatment Required to Address Newborn's Withdrawal Symptoms: Choose an item

i.1 If yes, indicate medication treatment and dosage *(name of medication and prescribed dosage):*

j. *Neonatal Abstinence Syndrome (*NAS*) Diagnosis: Choose an item

k. *Medical condition or ongoing health conditions *(type international classification of diseases ICD code and brief summary of newborns medical needs):*

l. *Newborn planned discharge date *(Select a date/calendar):* _____

m. *Address where newborn can be seen *(if hospital include the hospital name, address, unit, floor, and room number)*:
Choose an item _____

n. *Transfer to a pediatric center/hospital required to address medical condition: Choose an item
n.1 *If yes full name of hospital, hospital address and telephone number *(include the specific unit providing care for newborn):*

_____

o. *Address where newborn will reside upon discharge *(full address to include city, state & zip code):*

_____

p. *Name of the parent/s or caregiver newborn will reside with at discharge *(type Full Name):*

_____

Section III: PARENT/CAREGIVER INFORMATION

a. *Mother's Name *(type full name):* _____

b. *Date of Birth: (*M/D/YYYY*): _____

c. *Address where mother will reside if different from newborn's address in Section II *(full address to include city, state & zip code):*
_____ OR choose an item

d. *Mother's Phone Number *(indicate if cell or home)*: Home _____ OR choose an item

d.1 *Alternative or emergency contact number: Home _____ OR choose an item

e. *Father's Name *(type full name):* _____ OR choose an item

f. *Date of Birth (*M/D/YYYY*): _____

g. *Address where father will reside if different from newborn's address in Section II (*full address to include city, state & zip code*):
_____ OR choose an item

h. *Father's Phone Number *(indicate if cell or home)*: Home _____ OR choose an item

h.1 *Alternative or emergency contact number: Home _____ OR choose an item

i. Alternative Caregiver's Name: _____ OR choose an item

j. Date of Birth (*M/D/YYYY*): _____ OR choose an item

k. Address where caregiver will reside if different from newborn's address in Section II *(full address to include city, state & zip code)*:
_____ OR choose an item

l. Caregiver's Phone Number *(indicate if cell or home)*: Home _____

Section IV: REFERRAL INFORMATION

NEWBORN'S MOTHER

a. *Prenatal Care Started: _____ **b.** Mother substance use *select all that apply*:

Category - OPIOIDS ☐ Heroin/Schedule I ☐ Hydrocodone/Schedule II ☐ Buprenorphine/Schedule II ☐ Morphine/Schedule II
☐ Fentanyl/Schedule II ☐ Oxycodone/Schedule II ☐ Oxycodone-Percocet/Schedule II ☐ OxyContin/Schedule II ☐ Codeine/Schedule II
☐ Methadone/Schedule II Category - STIMULANTS ☐ Cocaine/Schedule II ☐ Methamphetamine/Schedule II
☐ Methylphenidate (Ritalin)/Schedule II ☐ Amphetamine/Schedule II ☐ *Adderall* ☐ *Vyvanse*
Category - DEPRESSANTS ☐ Benzodiazepine/Schedule IV ☐ *Valium* ☐ *Xanax* ☐ Barbiturates ☐ Alcohol
Category - HALLUCINOGENS and OTHER COMPOUNDS ☐ Marijuana/Schedule I ☐ Amphetamine/Schedule I- Ecstasy ☐ LSD/Schedule I
☐ Ketamine/Schedule III ☐ Phencyclidine (PCP)/Schedule II ☐ Other _____

c. *Mother self-reported date of last substance use (*select a date):* _____

d. *Mother self-reported current or past substance use treatment: Choose an item

If yes, list treatment last received *(include type of treatment i.e., medicated assisted treatment, residential, outpatient; name of treatment program; dates program attended):*

***PRESCRIPTION VERIFICATION**

e. *Mother self-reported controlled substance(*s*) prescribed: Choose an item

f. *Mother's prescription verified: Choose an item

f.1. *If no, reason prescription not verified (*type a brief narrative*):

g. *Name of prescriber: _____ **g.1.** *Telephone Number: _____

h. *Reported indication for prescribed controlled substance *(brief narrative to include name of substance prescribed, dosage, and compliance):*

i. Current or past mental health services self-reported by mother: Choose an item

j. Intellectual or Developmental Disability: Choose an item

k. Mother identified social support: Choose an item

l. Intimate Partner Violence self-reported by mother (*current or past*): Choose an item

NEWBORN'S FATHER

m. Current or past substance use: Choose an item

If yes, father substance use: *select all that apply*:

Category - OPIOIDS ☐ Heroin/Schedule I ☐ Hydrocodone/Schedule II ☐ Buprenorphine/Schedule II ☐ Morphine/Schedule II
☐ Fentanyl/Schedule II ☐ Oxycodone/Schedule II ☐ Oxycodone-Percocet/Schedule II ☐ OxyContin/Schedule II ☐ Codeine/Schedule II
☐ Methadone/Schedule II **Category - STIMULANTS** ☐ Cocaine/Schedule II ☐ Methamphetamine/Schedule II
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Category - DEPRESSANTS ☐ Benzodiazepine/Schedule IV ☐ *Valium* ☐ *Xanax* ☐ Barbiturates ☐ Alcohol
Category - HALLUCINOGENS and OTHER COMPOUNDS ☐ Marijuana/Schedule I ☐ Amphetamine/Schedule I- Ecstasy ☐ LSD/Schedule I
☐ Ketamine/Schedule III ☐ Phencyclidine (PCP)/Schedule II ☐ Other _____

n. Father self-reported date of last substance use *(select a date):* _____

o. Father self-reported current or past substance use treatment: Choose an item

If yes, list treatment last received (*include type of treatment i.e., medicated assisted treatment, residential, outpatient; name of treatment program; dates program attended*):

p. Father self-reported controlled substance(*s*) prescribed: Choose an item

q. Current or past mental health services self-reported by father: Choose an item

r. Intellectual or Developmental Disability: Choose an item

s. Father identified social support: Choose an item

t. Intimate Partner Violence self-reported by father (*current or past*): Choose an item

Section V: ADDITIONAL REFERRAL INFORMATION

a. *Preparations for newborn identified by mother, father, or caregiver: This may include identifying newborn's pediatrician, current newborn supplies such as car seat, crib bassinet, or etc.

a.1. *Pediatrician's contact information:

*Full Name: _____

*Telephone Number: _____

*Full Address: _____ OR choose an item

a.2. Next scheduled appointment date (if applicable) select a date: _____

b.*Provide any additional information that would assist LDSS staff in assessing safety and risk and a developing Plan of Safe Care. This may include but not limited to the following: Mother, father, or caregiver current or past involvement with Department of Social Services (DSS); Referrals made by hospital staff for newborn, parent/s, or caregiver such as Infants & Toddlers, Healthy Families, Postpartum Infant Maternal Referral (Medicaid recipient only); Additional children (biological, non-biological) of mother, father, or caregiver in their household, under care of state agency or care of relative; Behavioral observations i.e. mother/father unable to respond to newborn in a manner consistent with newborn development, mother/father having inability to control his/her emotional or physical behavior.

*Full name of LDSS staff person to whom oral report was made: _____

_____

*Reporter Signature

*Date Completed (*select a date):* _____

*Date Submitted to LDSS (*select a date):* _____

The completed form must be signed (electronic signature accepted) and emailed, faxed, or mailed to the LDSS where the newborn is expected to reside with email subject line title, "SEN Notification".

For a complete list of LDSS' CPS Screening and Intake contact numbers or email addresses visit
https://dhs.maryland.gov/child-protective-services/risk-of-harm/local-offices/

RESET FORM **PRINT FORM**