|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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.**/** | | | | | | |