ATTACHMENT E: INSTRUMENTS FOR MEDICAL STAFF

Attachment E-1

Newborn's Medical Record Audit

FEBRUARY 23, 2010 FORMAT

Readmit |__|
Initial |__|__|

Form Approved
OMB No. xxxx-xxxx
Expiration Date xx-xx-xxxx

DATE: |__|__| |__|__| |2|0|__|__| START TIME: |__|__| : |__|__| a.m. |__| p.m. |__| END TIME: |__|__| : |__|__|a.m. |__| p.m. |__|

MOTHER'S ID# |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

MOTHER'S GPRA INTAKE DATE |__|__| |__|__| |2|0|__|__|

CHILD'S DATE OF BIRTH |__|__| |__|__| |2|0|__|__|

EVALUATION PHASE: Intake |__| Delivery |__|

PERSON COMPLETING |_______________| GRANT# TI |__|__|__|__|__|__|__|

NEWBORN'S MEDICAL RECORD AUDIT

Please document the actual numbers of the information being requested below. Record the child's ID on top of each column. (Extra columns are provided for twins/multiple births.)

Complete if child born to mother while she is in treatment or if child is less than 3 months old at intake.

	CHILD |__|__|	CHILD |__|__|	CHILD |__|__|	CHILD |__|__|
Apgar score	|__|__|	|__|__|	|__|__|	|__|__|
Head circumference	|__|__|.|__| CM ☐ IN ☐	|__|__|.|__| CM ☐ IN ☐	|__|__|.|__| CM ☐ IN ☐	|__|__|.|__| CM ☐ IN ☐
Length at birth	|__|__|.|__| CM ☐ IN ☐	|__|__|.|__| CM ☐ IN ☐	|__|__|.|__| CM ☐ IN ☐	|__|__|.|__| CM ☐ IN ☐
Birth weight	|__|__|.|__|__| KG ☐ LB ☐	|__|__|.|__|__| KG ☐ LB ☐	|__|__|.|__|__| KG ☐ LB ☐	|__|__|.|__|__| KG ☐ LB ☐
Gestational age	|__|__|.|__|__| in weeks	|__|__|.|__|__| in weeks	|__|__|.|__|__| in weeks	|__|__|.|__|__| in weeks
Drug screen	|__| NEGATIVE |__| COCAINE |__| METHADONE |__| OTHER OPIATES |__| MARIJUANA |__| METHAMPHETAMINE |__| ALCOHOL |__| NICOTINE |__| OTHER POSITIVE ______________ ______________	|__| NEGATIVE |__| COCAINE |__| METHADONE |__| OTHER OPIATES |__| MARIJUANA |__| METHAMPHETAMINE |__| ALCOHOL |__| NICOTINE |__| OTHER POSITIVE ______________ ______________	|__| NEGATIVE |__| COCAINE |__| METHADONE |__| OTHER OPIATES |__| MARIJUANA |__| METHAMPHETAMINE |__| ALCOHOL |__| NICOTINE |__| OTHER POSITIVE ______________ ______________	|__| NEGATIVE |__| COCAINE |__| METHADONE |__| OTHER OPIATES |__| MARIJUANA |__| METHAMPHETAMINE |__| ALCOHOL |__| NICOTINE |__| OTHER POSITIVE ______________ ______________

Attachment E-2

Staff Completed Newborn Items

READMIT |__|
INITIALS |__|__|

DATE: |__|__| |__|__| |2|0|__|__| START TIME: |__|__| : |__|__| a.m. |__| p.m. |__| END TIME: |__|__| : |__|__|a.m. |__| p.m. |__|

MOTHER'S ID# |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| MOTHER'S GPRA INTAKE DATE |__|__| |__|__| |2|0|__|__|

CHILD'S DATE OF BIRTH |__|__| |__|__| |2|0|__|__| EVALUATION PHASE: Intake |__| Delivery |__|

PERSON COMPLETING |_____| GRANT# **TI** |__|__|__|__|__|__|

INTAKE: STAFF COMPLETED NEWBORN ITEMS

This tool should be completed by project staff for each child born to a woman in treatment or within 3 months of her intake date. Please document the information requested below as specified in the Newborn's medical record. If the requested information is not included in the medical record, please select "Not specified". Record the child's ID on top of each column. *(Project staff should complete one form for each birth. Extra columns are provided for twins/multiple births.)*

ITEM	CHILD ID |__|__|	CHILD ID |__|__|	CHILD ID|__|__|
1. Was this newborn born premature (less than 37 weeks gestation)?	Yes |__| No |__| Not specified |__|	Yes |__| No |__| Not specified |__|	Yes |__| No |__| Not specified |__|
2. Did this newborn have any congenital anomalies or birth complications?	Yes |__| No |__| Not specified |__|	Yes |__| No |__| Not specified |__|	Yes |__| No |__| Not specified |__|
a. If YES, please specify.	_____ _____ _____ Not specified |__| N/A |__|	_____ _____ _____ Not specified |__| N/A |__|	_____ _____ _____ Not specified |__| N/A |__|
3. Newborn Hospital Discharge Date/Time	|__|__| month |__|__| day |__|__|__|__| year |__|__|: |__|__| time AM |__| PM |__|	|__|__| month |__|__| day |__|__|__|__| year |__|__|: |__|__| time AM |__| PM |__|	|__|__| month |__|__| day |__|__|__|__| year |__|__|: |__|__| time AM |__| PM |__|
4. If newborn's length of stay in hospital is greater than 3 days, please specify why.	Child needed care|__| Mother needed care |__| Social service concern|__| Other _____ |__| Not specified |__| N/A |__|	Child needed care|__| Mother needed care |__| Social service concern|__| Other _____ |__| Not specified |__| N/A |__|	Child needed care|__| Mother needed care |__| Social service concern|__| Other _____ |__| Not specified |__| N/A |__|
5. Was newborn admitted to NICU?	Yes |__| No |__| Not specified |__|	Yes |__| No |__| Not specified |__|	Yes |__| No |__| Not specified |__|
a. If YES, please specify why newborn was sent to NICU.	_____ _____ _____ Not specified |__| N/A |__|	_____ _____ _____ Not specified |__| N/A |__|	_____ _____ _____ Not specified |__| N/A |__|
b. If YES, Newborn Admission to NICU Date/Time	|__|__| month |__|__| day |__|__|__|__| year |__|__|: |__|__| time	|__|__| month |__|__| day |__|__|__|__| year |__|__|: |__|__| time	|__|__| month |__|__| day |__|__|__|__| year |__|__|: |__|__| time

	AM |__| PM |__| N/A |__|	AM |__| PM |__| N/A |__|	AM |__| PM |__| N/A |__|
c. If YES, Newborn Discharge from NICU Date/Time	|__|__| month |__|__| day |__|__|__|__| year |__|__|: |__|__| time AM |__| PM |__| N/A |__|	|__|__| month |__|__| day |__|__|__|__| year |__|__|: |__|__| time AM |__| PM |__| N/A |__|	|__|__| month |__|__| day |__|__|__|__| year |__|__|: |__|__| time AM |__| PM |__| N/A |__|
6. Was newborn diagnosed with Neonatal Abstinence Syndrome (NAS)?	Yes|__| No|__| Not specified|__|	Yes|__| No|__| Not specified|__|	Yes|__| No|__| Not specified|__|
a. If YES, is NAS due to maternal substance use?	Yes|__| No|__| Not specified|__| N/A |__|	Yes|__| No|__| Not specified|__| N/A |__|	Yes|__| No|__| Not specified|__| N/A |__|
b. If YES, was NAS treated?	Yes|__| No|__| Not specified|__| N/A |__|	Yes|__| No|__| Not specified|__| N/A |__|	Yes|__| No|__| Not specified|__| N/A |__|
c. If YES, what treatments, specifically for NAS, did the newborn receive?	_____ _____ _____ Not specified |__| N/A |__|	_____ _____ _____ Not specified |__| N/A |__|	_____ _____ _____ Not specified |__| N/A |__|