### ATTACHMENT E: INSTRUMENTS FOR MEDICAL STAFF

E-1 Newborn's Medical Record Audit

E-2 Staff Completed Newborn Items

## **Attachment E-1**

### **Newborn's Medical Record Audit**

#### FEBRUARY 23, 2010 FORMAT

Readmit    Initial   _			E	Form Approved OMB No. xxxx-xxxx Expiration Date xx-xx-xxxx				
DATE:  _     _	<mark>2 0</mark>     STA		a.m.    END TIME: p.m.	_  :   a.m.    p.m.				
MOTHER'S ID#								
MOTHER'S GPRA INTAKE DATE								
CHILD'S DATE OF BIR	ктн <u>                                    </u>	<u><b>o</b>  </u>						
EVALUATION PHASE:	Intake    Delivery	<u>L</u> l						
PERSON COMPLETIN	PERSON COMPLETING   GRANT# <b>TI</b>							
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	n to mother while she is i	n treatment or if child is	less than 3 months old at	t intake.				
A	CHILD	CHILD	CHILD	CHILD				
Apgar score	_ _	_ _	_ _					
Head circumference	_ - - -  CM	_ - - -  CM	_ _ -  -  CM	. _  CM				
Length at birth	_ _ . _  CM							
Birth weight	_ _ -   KG	_ _ -   KG	_ _ -   KG	_ _ . _  KG				
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				

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Public reporting burden for this collection of information is estimated to average 5 minutes per response; including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information to SAMHSA Reports Clearance Officer, Room 7-1044, 1 Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The control number for this project is 0930-0269.

## **Attachment E-2**

# **Staff Completed Newborn Items**

READMIT    INITIALS   _							
DATE:							
MOTHER'S ID#                         MOTHER'S GPRA INTAKE DATE							
CHILD'S DATE OF BIRTH                         EVALUATION PHASE: Intake   Delivery							
PERSON COMPLETING GRANT# <b>TI</b>							
INT	AKE: STAFF COMPL	ETED NEWBORN IT	EMS				
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. ( <i>Project staff should complete one form for each birth. Extra columns are provided for twins/multiple births.</i> )							
ITEM	CHILD ID	CHILD ID	CHILD ID				
Was this newborn born premature (less than 37 weeks gestation)?	Yes    No    Not specified	Yes    No    Not specified	Yes    No    Not specified				
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	Not specified	Not specified				
Newborn Hospital     Discharge Date/Time	_   month   _   day   _   year   _ :     time   AM     PM	_   month   _   day   _   year   _  :     time   AM	_   month   _   day   _   year   _				
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	Not specified				
b. If YES, Newborn Admission to NICU Date/Time	_   month   _   day   _    year   _  :      time	_   month   _   day   _   _    year   _  :  _    time	_ month   _ day   _ _  year   _ _ :    time				

		AM    PM	AM    PM	AM    PM
		N/A	N/A	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	Not specified