



Tennessee Department of Children's Services
Drug Exposed Child Intake

Case Name:	ACV Name/DOB:	Date of Referral:
Date/Time of Contact:	Location of Contact:	Hospital:
Mother's Name:	Father's Name: <input type="checkbox"/> Legal <input type="checkbox"/> Alleged	Siblings: Same Father as ACV? <input type="checkbox"/> Yes <input type="checkbox"/> No

Hospital Protocol- *Contact with the hospital within 24 hours of assignment.*

Household Composition *All household member's names, DOB, and relationship to ACV.*

BIRTH/PRENATAL INFORMATION

- Vaginal/C-Section Delivery?
- Pregnancy Complications?
- Delivered Full-Term? Weeks?
- When/How learned pregnant?

5. Prenatal Care Yes No Regular?
6. OB/GYN?
7. First Prenatal Appointment?
8. Did the father attend prenatal appointments? Yes No
9. Breastfeeding or Bottle Feeding? Breastfeeding Bottle Feeding
10. Smoker or Non-Smoker? Smoker Non-Smoker
11. Did mother smoke or use tobacco during pregnancy? Yes No
- Type? How Much? How Often?
12. NAS/FAS?

Mother's Substance Use (Pregnancy)

1. Urine Drug Screen (UDS) upon admission? Yes No
2. Substances used during the pregnancy.
- A. Marijuana? Yes No
- How often?
 - Type (Concentrate, Edibles, or Plant)?
 - Method of Use?
 - Amount?
 - Age of first use?
- B. Opiates? Yes No
- How often?
 - Type of Opiate used?
 - Method of Use?
 - Amount?
 - Age of first use?

C. Heroin? Yes No

- i. How often?
- ii. Method of Use?
- iii. Amount?
- iv. Age of First Use?

D. Cocaine? Yes No

- i. How often?
- ii. Method of Use?
- iii. Amount?
- iv. Age of First use?

E. Methamphetamine? Yes No

- i. How often?
- ii. Method of Use?
- iii. Amount?
- iv. Age of First Use?

F. Amphetamine? Yes No

- i. How often?
- ii. Type of Amphetamine?
- iii. Method of Use?
- iv. Amount?
- v. Age of First Use?

G. MDMA Yes No

- i. How often?
- ii. Method of Use?
- iii. Amount?
- iv. Age of First use?

H. Buprenorphine? Yes No

- i. How often?
- ii. Method of Use?

- iii. Amount?
- iv. Prescribed?
- v. Age of First Use?
- I. Methadone? Yes No
 - i. How often?
 - ii. Method of Use?
 - iii. Amount?
 - iv. Age of First Use?
- J. Alcohol? Yes No
 - i. How Often?
 - ii. Amount?
 - iii. Type?
 - iv. Age of First Use?
- K. Benzodiazepines Yes No
 - i. How Often?
 - ii. Amount?
 - iii. Type?
 - iv. Age of First Use?
- L. Fentanyl Yes No
 - i. How Often?
 - ii. Amount?
 - iii. Method Used?
 - iv. Age of First Use?
- M. Any other substances used not listed above?

3. Was OB/GYN aware of substance use during pregnancy? Yes No
4. Did physician discuss or warn mother of substance use during the pregnancy?
 Yes No
5. Does mother acknowledge that she was aware that substance use can be harmful to an unborn baby? Yes No

Medication Assisted Treatment (MAT)?

- a. Name of clinic and prescribing physician?
- b. How long has mother been receiving MAT?
- c. How long has mother been attending current clinic?
- d. Has mother received MAT at other clinics?
- e. Plan (wean or maintain)?
- f. Was release of information obtained? Yes No
- g. How is treatment paid for?

Mother's Substance Use (History)

Timeline of substance use history to include all substances used in the past, age when used, duration of time used, and method of use. Also, include any past substance use treatment and any family history of substance use.

Alcohol Use?

Please discuss the current use of alcohol regarding frequency and amount?

Mother-Mental Health (Current/History)

Current or past mental health diagnosis, treatment medication.

Traumatic Experiences

a. Childhood Experiences- Anything that occurred during your childhood that stands out in your mind.

b. Did your parents use drugs or alcohol? Yes No

c. Did you experience domestic violence in your home when you were a child?

Yes No

Domestic Violence (current/past)

Any previous substance use treatment?

Mother-Criminal Activity (Current/History)

Please include charges, jail sentences, probation information, and upcoming court dates.

Father's Substance Use (Current/History)

Timeline of substance use history to include all substances used in the past, age when used, duration of time used, and method of use. Also, include any past substance use treatment and any family history of substance use.

Alcohol Use?

Please discuss the current use of alcohol in regarding to frequency and amount?

Father's Medication Assisted Treatment *if applicable*

- a. Name of clinic and prescribing physician?
- b. How long has father been receiving MAT?
- c. How long has father been attending current clinic?
- d. Has father received MAT at other clinics?
- e. Plan (wean or maintain)?
- f. Was release of information obtained? Yes No
- g. How is treatment paid for?

Father's-Mental Health (Current/History)

Current or past mental health diagnosis, treatment medication.

Traumatic Experiences

- a. **Childhood Experiences- Anything that occurred during your childhood that stands out in your mind.**

Did your parents use drugs or alcohol? Yes No

- b. **Did you experience domestic violence in your home when you were a child?**

Yes No

Domestic Violence

Father's-Criminal Activity (Current/History)

Please include charges, jail sentences, probation information, and upcoming court dates.

Any previous substance use history?

Other Household Members' Substance Use (Current/History)

Timeline of substance use history to include all substances used in the past, age when used, duration of time used, and method of use. Also, include any past substance use treatment and any family history of substance use.

Alcohol Use?

Please discuss the current use of alcohol in regarding to frequency and amount?

Financial Resources and Other Information

Mother Employed? Yes No Where? How Long?

Father Employed? Yes No Where? How Long?

Food Stamps? Yes No

Enrolled in WIC? Yes No

TennCare?

Mother- Yes No

Father- Yes No

Children- Yes No

Other Income?

Other Financial Support?

Transportation?

Mother- Valid Driver's License

Father- Valid Driver's License

Parent's Education Level?

Formal and Informal Supports: *Family Supports, Pediatrician, Schools, etc.*

Home Observation and Safe Sleep

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

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Return to Use Plan

Staffing Cases

All cases are to be staffed with supervision by the end of the week in which the initial response was met. Cases with an immediate safety concern will require immediate staffing. *Each Team Leader may have their own protocol for staffing.*

Home Visit

Please document a description of the home. Is the home an apartment, trailer, house, etc....? If you observe the home to “cluttered” please explain what that looks like. If you are saying the home is clean and organized, please explain what that looks like.

Complete a thorough walkthrough of the home. This includes looking in each room to ensure that no safety concerns are present. Document what you observe. If the home has no safety concerns, your documentation should reflect why there is no safety concerns. Please do not simply say “no safety concerns observed” or “home was appropriate.”

Safe Sleep

Verify safe sleep and document what the safe sleep environment looks like. You should be discussing safe sleep with **each contact** you make with the family until the case is closed, and you should always verify the safe sleep space each time you visit the home to ensure that the sleep space is free of items that could be dangerous to the infant.

COMPLETE THE SAFE SLEEP ASSESSMENT WITH THE FAMILY AT THE INITIAL HOME VISIT. This document should be signed and uploaded in TFACTS.

Service Providers and Medical Professionals

If a service is needed, please refer that service ASAP from the point the need is identified. Please ensure that we are following up with service providers for updates and document those contacts. If the service provider emails you with updates, please document in TFACTS, but do not copy and paste the email.

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*If the parent or parents are involved in Medication Assisted Treatment, please ensure you are getting records at the beginning of the case. Also, please ensure that you are following up with the provider before closing or transferring the case to ensure that they are still being compliant with treatment provider and verify that they are not testing positive for anything outside of their prescribed medication.

Monthly Face to Face Contacts

Our infants need to be seen MONTHLY (calendar month) and not just every 30 days. Policy states "calendar month." We work with a very vulnerable population and we must see the babies every month.

Release of Information

Please obtain signed releases at the initial contact with the family whenever possible. There should only be a few incidences when this would not be possible.

Plan of Safe Care Signature Pages

Please ensure that you are getting signature pages signed when completing Plan of Safe Care. These pages have to be uploaded in TFACTS.

Pediatrician

Prior to closing your case, contact should be made with the infant's pediatrician to ensure that the parents are being compliant with the child's medical appointments. Also, to learn if they have any concerns. You can also utilize Kelly Busbee (BlueCare case manager for infants and children) for this these updates if the child has BlueCare. She is a great resource.

If we are referring to TEIS and HUGS, please contact these providers prior to closing the case to see if the parents are being compliant and working with the services.

Safety Nurse

If the child has a medical condition (does not include NAS) you must notify the safety nurse, Betsy Lowe, or whoever is covering for her, to discuss if any other services or recommendations need to be discussed with the family. Please document in TFACTS that you have had this conversation. Her contact information is 865-696-7147 or 865-227-3945.