

# Substance Exposed Workgroup Staffing Sheet

Staffing Date \_\_\_\_\_ Staffing Risk Level \_\_\_\_\_

Client's Name \_\_\_\_\_ DOB \_\_\_\_\_ Location \_\_\_\_\_

LMP \_\_\_\_\_ EDC \_\_\_\_\_ Weeks Pregnant \_\_\_\_\_ Post Partum \_\_\_\_\_

Occupation \_\_\_\_\_ Prenatal Provider \_\_\_\_\_ Phone \_\_\_\_\_

Other Children \_\_\_\_\_ DOB \_\_\_\_\_ Location \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_ Location \_\_\_\_\_

Methadone/Drug Abuse Hx \_\_\_\_\_

Tobacco Use \_\_\_\_\_ Alcohol Use \_\_\_\_\_

Current Opioid Dose \_\_\_\_\_

Current Opioid Prescriber \_\_\_\_\_ Phone \_\_\_\_\_

Current Opioid Provider \_\_\_\_\_ Phone \_\_\_\_\_

Cost to Client \_\_\_\_\_ Medicaid (*circle one*) Yes / No

Last UDS on Client Date \_\_\_\_\_ Results \_\_\_\_\_

Agency \_\_\_\_\_

Enrolled in Healthy Start YES  NO

Last Face to Face \_\_\_\_\_ Healthy Start Level (*circle one*) 1 2 3 4

Healthy Start Case Manager \_\_\_\_\_ Phone \_\_\_\_\_

Last Healthy Start Meeting \_\_\_\_\_

BPS Completed YES  NO  Date Evaluation Completed \_\_\_\_\_

Recommendations \_\_\_\_\_

Out Patient  Day/Night  Residential Level (*circle one*) I II III

Treatment Start \_\_\_\_\_

Birth Plan \_\_\_\_\_ Hospital \_\_\_\_\_

Plan for Infant  Keep  Adoption  Foster Care

Support System Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Social Worker Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Pediatrician \_\_\_\_\_ Phone \_\_\_\_\_

Other Services/Activities Contributing Toward Case Plan \_\_\_\_\_

Concerns \_\_\_\_\_

Actions \_\_\_\_\_

Breastfeeding \_\_\_\_\_

Bottle \_\_\_\_\_

Risk Reduction Evaluation \_\_\_\_\_

HIV Status \_\_\_\_\_

Hepatitis B Status \_\_\_\_\_

Consent on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Early Steps Referral	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HS Screen on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No	DCF Referral	<input type="checkbox"/> Yes	<input type="checkbox"/> No
CMS Referral	<input type="checkbox"/> Yes	<input type="checkbox"/> No	CPC Referral	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			WIS Referral	<input type="checkbox"/> Yes	<input type="checkbox"/> No