State of Nevada
Division of Public and Behavioral Health

Comprehensive Addiction and Recovery Act (CARA)
Plan of Care - PART A

HOSPITAL REPRESENTATIVE, for all infants known or with reasonable cause to believe born with a fetal alcohol spectrum disorder, affected by substance use, or experiencing symptoms of withdrawal from a drug as a result of exposure to the drug in utero, please:

1. Complete the Plan of Care with the infant's family/caregiver;
2. Provide a copy of **Part B** of the Plan to the infant's family/caregiver; and
3. Provide a copy of **Parts A and B** of the Plan to DPBH within **24 hours** of infant's discharge.

Section I Hospital Information	
Name of Hospital:	
Hospital primary care physician:	**Actual infant discharge date:**
Name and title of person completing form:	**Phone number:** ( )

Section II: Infant's Information		
First name:	**Last name:**	
DOB: **(mm/dd/yyyy)**	**Sex:**	
Gestational age at time of birth (weeks):		
Birth weight: (lbs) (oz)	**Apgar score** (1 min.) (5 min.)	**Head circumference:** (cm)
Newborn exposure related complications? □ Yes □ No - **If yes, please note:**		
Was breastfeeding initiated? □ Yes □ No - **If no, please note:**		
Was non-pharmacological Intervention initiated? □ Yes □ No - **If yes, please note:**		

Section III: CPS Notification and Infant's placement
Was a CPS notification made? □ **Yes** □ **No If yes, CPS referral Number:**
Was infant placed with a caregiver other than parent? □ Yes □ No - **If yes, complete Section IV below.**

Section IV: Caregiver Information (Complete this section if infant has been placed with caregiver other than parent)		
First name:	**Last name:**	**Phone number:** ( )
Street address:		**City:**
State:	**Zip:**	**County:**

Section V: Mother's Information		
First name:	**Last name:**	
Phone number: ( )	**SSN:**	**DOB:** (mm/dd/yyyy)
Street address:		

City:	**State:**	**Zip:**	**County:**

Section VI: Mother's Prenatal Care and Behavioral Health
Prenatal care? □ Yes □ No - **If yes, initial visit at how many weeks?** (gestational age):
Toxicology Report? □ Yes □ No - **If yes, please attach toxicology report.**
Behavioral health history? □ Yes □ No - **If yes, please note:**

Section VII: Father's Information		
First name:	**Last name:**	
Phone number: ( )	**SSN:**	**DOB:** (mm/dd/yyyy)
□ Check here if father's address is same as the mother's address.		
Street address:		

City:	**State:**	**Zip:**	**County:**

Section VIII: Mother's Substance Exposure	
Is mother willing to speak about her substance exposure? □ Yes □ No	
Check all that apply	**Method of use**
□ Alcohol	N/A
□ Barbiturates	□ Inhalation □ Injection □ Oral □ Other
□ Benzodiazepines	□ Inhalation □ Injection □ Oral □ Other
□ Cocaine/Crack	□ Inhalation □ Injection □ Oral □ Other □ Smoking
□ Hallucinogens (LSD, PCP/angel dust)	□ Inhalation □ Injection □ Oral □ Other □ Smoking
□ Inhalants (gasoline, glue, hairspray, other aerosols)	□ Inhalation
□ Marijuana/Hashish	□ Oral □ Other □ Smoking □ Topical
□ Methamphetamine/Amphetamines (ice, crank, crystal, ice, uppers, speed)	□ Inhalation □ Injection □ Oral □ Other □ Smoking
□ Opioids - **Non-Prescribed** (fentanyl, heroin, hydrocodone, oxycodone, methadone) If other, please specify:	□ Inhalation □ Injection □ Oral □ Other □ Smoking
□ Opioids - **Prescribed** (buprenorphine (Subutex/Suboxone), fentanyl, hydrocodone, oxycodone, methadone) If other, please specify:	□ Inhalation □ Injection □ Oral □ Other □ Smoking
□ Stimulants (Adderall, Ritalin)	□ Inhalation □ Injection □ Oral □ Other □ Smoking
□ Synthetic (Bath Salts, E, Ecstasy, K2, MDMA, Molly, Spice) If other, please specify:	□ Inhalation □ Injection □ Oral □ Other □ Smoking
□ Tobacco use	□ Cigarettes □ Chewing tobacco □ Electronic nicotine products
□ Tranquilizers (downers, ludes) If other, please specify:	□ Inhalation □ Injection □ Oral □ Other □ Smoking
□ Over the Counter	□ Inhalation □ Injection □ Oral □ Other □ Smoking
□ Other (please specify):	□ Inhalation □ Injection □ Oral □ Other □ Smoking
Any notes, if applicable:	

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CARA Plan of Care - PART B

Infant's family/caregiver and hospital representative complete PART B together.

Section I: Referrals, Education, and Plan of Care

Type of referrals/education needed:	Current	New	N/A	Person/Organization and Contact Information
Child Care & Head Start	□	□	□	
Contraceptive Health	□	□	□	
Early Intervention	□	□	□	
Education, Employment, Legal, & Financial Assistance	□	□	□	
Food, Clothing, Housing, Energy, Transportation & Emergency Shelter Assistance	□	□	□	
Hepatitis B and C Information	□	□	□	
Home Visiting	□	□	□	
Insurance Assistance	□	□	□	
Maternal Lactation Education	□	□	□	
Medical Services	□	□	□	
Parenting Groups	□	□	□	
Pediatrician	□	□	□	
Post-Partum Depression Education	□	□	□	
Respite Care	□	□	□	
Safe Sleep Plan	□	□	□	
Substance Use Services	□	□	□	
Tribal Services	□	□	□	
Women Infants & Children (WIC)	□	□	□	
Other - please note:	□	□	□	

Was mother engaged in services prior to delivery? □ **Yes** □ **No - If yes, please list:**

Section II: Other Participants in the CARA Plan of Care

Who else other than mother/father/caregiver is going to participate in the Plan of Care?

Name:	**Phone number: ( )**

Relationship to infant: □ aunt □ grandfather □ grandmother □ other relative □ roommate □ sibling □ uncle □ other - **If other relation, please note:**

Signatures:

Parent/caregiver:	**Staff:**
Date of signature:	**Date of signature:**