State of Nevada
Division of Public and Behavioral Health

# CARA Plan of Care

Comprehensive Addiction Recovery Act or "CARA" Plan of Care must be developed with the family/caregiver and documented for all screened-intakes identifying a newborn as affected by substance(s).

| **Hospital:** | **Phone number:** ( ) |
|---|---|
| **Name and title of person completing form:** | **Date completed:** |

**Section I Parent's Information:**

**Mother's Information**

| **First name:** | | **Last name:** | |
|---|---|---|---|
| **Phone number:** ( ) | **SSN:** | **DOB:** (mm/dd/yyyy) | |
| **Street address:** | | | |
| **City:** | **State:** | **Zip:** | **County:** |

**Ethnicity:** □ Hispanic/Latino □ not Hispanic/Latino □ unknown or did not report

| **Race:** | **Education level:** | **Annual household income:** |
|---|---|---|
| □ Black/African American | □ Currently attends high school | □ Less than $10,000 |
| □ Native American/Alaska Native | □ High school age does not attend | □ $10,000 to $20,000 |
| □ Asian | □ High school diploma/GED complete | □ $20,001 to $30,000 |
| □ White/Caucasian | □ Enrolled in college | □ $30,001 to $40,000 |
| □ Native Hawaiian/Pacific Islander | □ Some college completed | □ $40,001 to $50,000 |
| □ Refuse to Identify/Unknown Race | □ Associate Degree attained | □ More than $50,000 |
| □ Multiracial | □ Bachelor's Degree or higher attained | |

**Currently employed?** □ Yes □ No – **If yes, please note occupation:**

**Marital Status:** □ single (never married) □ married □ divorced □ separated □ living together (not married) □ widowed

**Father's Information**

| **First name:** | | **Last name:** | |
|---|---|---|---|
| **Phone number:** ( ) | **SSN:** | **DOB:** (mm/dd/yyyy) | |

□ Check here if address is same as mother's and skip to Ethnicity question.

| **Street address:** | | | |
|---|---|---|---|
| **City:** | **State:** | **Zip:** | **County:** |

**Ethnicity:** □ Hispanic/Latino □ not Hispanic/Latino □ unknown or did not report

| **Race:** | **Education level:** | **Annual household income:** |
|---|---|---|
| □ Black/African American | □ Currently attends high school | □ Less than $10,000 |
| □ Native American/Alaska Native | □ High school age does not attend | □ $10,000 to $20,000 |
| □ Asian | □ High school diploma/GED complete | □ $20,001 to $30,000 |
| □ White/Caucasian | □ Enrolled in college | □ $30,001 to $40,000 |
| □ Native Hawaiian/Pacific Islander | □ Some college completed | □ $40,001 to $50,000 |
| □ Refuse to Identify/Unknown Race | □ Associate Degree attained | □ More than $50,000 |
| □ Multiracial | □ Bachelor's Degree or higher attained | |

**Currently employed?** □ Yes □ No – **If yes, please note occupation:**

**Marital Status:** □ single (never married) □ married □ divorced □ separated □ living together (not married) □ widowed

| **Section II Infant's Information:** | | |
|---|---|---|
| **First name:** | **Last name:** | |
| **Hospital Primary Care Physician:** | **DOB:** (mm/dd/yyyy) | **Sex:** |
| **Gestational age at time of birth (weeks):** | **Growth Percentile:** | |
| **Birth weight:** (lbs) (oz) | **Apgar score** (1 min.) (5 min.) | **Head circumference:** (cm) |
| **Ethnicity:** □ Hispanic/Latino □ not Hispanic/Latino □ unknown or did not report | | |
| **Race:** □ Black/African American □ Native American/Alaska Native □ Asian □ White/Caucasian □ Native Hawaiian/Pacific Islander □ Refuse to Identify/Unknown Race □ Multiracial | | |
| **Newborn complications?** □ Yes □ No - **If yes, please note:** | | |
| **Infant medical diagnosis?** □ Yes □ No - **If yes, please note:** | | |
| **Medical Home Pediatrician:** | **Health insurance provider (optional):** | |
| **Was breastfeeding initiated?** □ Yes □ No - **If no, why? Please note:** | | |
| **Was non-pharmacological Intervention initiated?** □ Yes □ No - **If yes, please note:** | | |
| **Hospital Admission date:** (mm/dd/yyyy) | **Anticipated Hospital Discharge Date:** (mm/dd/yyyy) | |
| **Infant's placement** | | |
| **Was a CPS report made?** □ Yes □ No **CPS referral Number:** | | |
| **Where was infant placed?** □ with biological mother □ with biological father □ with both biological parents □ with licensed foster parent □ with relative caregiver □ with non-relative caregiver | | |
| **Caregiver Information (Complete this section If infant has been placed with a caregiver)** | | |
| **First name:** | **Last name:** | **Phone number:** ( ) |
| **Street address:** | | **City:** |
| **State:** | **Zip:** | **County:** |

| **Section III Mother's Health and Prenatal Care:** | | |
|---|---|---|
| **Prenatal care?** □ Yes □ No | **If yes, initial visit at how many weeks?** (gestational age): | |
| **Pre-pregnancy height:** (inches) | **Pre-pregnancy weight:** (lbs) | **Number of previous births:** |
| **Date of last live birth** (if applicable): | **Number of terminations** (if applicable): | |
| **Toxicology Report?** □ Yes □ No **- If yes, please attach toxicology report.** | | |
| **Obstetric Procedures (check all that apply):** □ Cervical cerclage □ Tocolysis □ none of these □ not specified | | |
| **Mode of delivery:** □ Vaginal □ C-Section □ Vaginal birth after previous C-section □ Repeat C-section □ Unknown | | |
| **Has mother received the Hep B vaccine?** □ Yes □ No **If no, was Hep B screening received?** □ Yes □ No | | |
| **Has mother been tested for Hep C?** □ Yes □ No **If yes, what were the results?** □ Pos □ Neg | | |
| **Was prenatal syphilis testing completed?** □ Yes □ No **If yes, during which trimester?** □ 1st □ 3rd □ Both 1st and 3rd | | |
| **Pregnancy complications?** □ Yes □ No **If yes, please note:** | | |
| **Mother's medical history:** | | |
| **Mental health history?** □ Yes □ No **If yes, please note:** | | |
| **Substance use history?** □ Yes □ No **If yes, please note:** | | |

| Section IV Exposures: | | | | |
|---|---|---|---|---|
| **Is patient willing to speak about their drug use? □ Yes □ No** | | **During which trimester did use occur?** | | |
| **Check all that apply:** | **Method of use** | **First** | **Second** | **Third** |
| □ **Tobacco use?** | □ Cigarettes<br>□ Chewing tobacco | □ | □ | □ |
| | □ Electronic nicotine products | □ | □ | □ |
| □ **Alcohol use?** | N/A | □ | □ | □ |
| □ **Marijuana use? If yes, what kind?**<br>□ Flower □ Concentrates | □ Inhalation (smoking, vaping, dabbing)<br>□ Oral (oils, tinctures, edibles)<br>□ Topical (creams, oils) | □ | □ | □ |
| **Prescription drug use? □ Yes □ No**<br>**If yes, what kind?**<br>□ Opioids, methadone, and/or fentanyl<br>□ Buprenorphine (Subutex/Suboxone)<br>□ Other (please specify): | □ Swallowed<br>□ Snorted<br>□ Injected | □ | □ | □ |
| □ **Over the counter drug use?**<br>If yes, what kind? | N/A | □ | □ | □ |
| **Illicit Drug Use** | | | | |
| □ Amphetamines (meth, uppers, ice, crystal, speed, crank) | | □ | □ | □ |
| □ Barbiturates | | □ | □ | □ |
| □ Benzodiazepines | | □ | □ | □ |
| □ Cocaine | | □ | □ | □ |
| □ Ecstasy (E, Molly, MDMA) | | □ | □ | □ |
| □ Inhalants (sniffing gasoline, glue, hairspray, or other aerosols) | | □ | □ | □ |
| □ Heroin | | □ | □ | □ |
| □ Hallucinogens (LSD/acid, PCP/angel dust) | | □ | □ | □ |
| □ Opioids (methadone, oxycodone, hydrocodone, fentanyl) | | □ | □ | □ |
| □ Tranquilizers (downers, ludes) | | □ | □ | □ |
| □ Stimulants (Adderall, Ritalin, other) | | □ | □ | □ |
| □ Other (please specify): | | □ | □ | □ |
| **Intravenous drug user?** □ Yes □ No | | | | |
| **Notes:** | | | | |
| | | | | |
| | | | | |

## CARA Plan of Care

This portion of the CARA Plan of Care form must be completed with the infant's family/caregiver supports. Upon completion, provide a copy of page 4 and 5 to the infant's family/caregiver.

| Section V Referrals and Plan of Care | | | | |
|---|---|---|---|---|
| **Type of referrals needed:** | **Current** | **New** | **Person/Organization** | **Contact Information** |
| Substance Use Services | ☐ | ☐ | | |
| Contraceptive Health ie. (LARC) Long Acting Reversible Contraceptive | ☐ | ☐ | | |
| Medical Services & Insurance Assistance | ☐ | ☐ | | |
| Safe Sleep Plan | ☐ | ☐ | | |
| Mental Health | ☐ | ☐ | | |
| WIC | ☐ | ☐ | | |
| Early Intervention | ☐ | ☐ | | |
| Food, Clothing, Housing, Energy, Transportation & Emergency Shelter Assistance | ☐ | ☐ | | |
| Home Visiting | ☐ | ☐ | | |
| Licensed Daycare Facilities & Child Care | ☐ | ☐ | | |
| Education, Employment, Legal & Financial Assistance | ☐ | ☐ | | |
| Respite Care | ☐ | ☐ | | |
| Tribal Services | ☐ | ☐ | | |
| Parenting Groups | ☐ | ☐ | | |
| Other - please note: | ☐ | ☐ | | |

| Was mother engaged in services prior to delivery? Y/N<br>Which services were engaged? |
|---|
| |
| |
| |

| Follow-up Plan: |
|---|
| **Post-discharge family strengths and goals:** |
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| |
| |
| |
| **List family's resources:** |
| |
| |
| |
| |
| **List monitoring provider(s) if known:** |
| |
| |
| |
| |

| Participants in the Plan of Care | | |
|---|---|---|
| Who else other than the mother/father/caregiver are going to participate in the CARA Plan of Care? How many participants are expected? ________ | | |
| **Name:** | **Phone number:** | **Age:** |
| **Relationship to infant:** □ foster parent □ sibling □ grandmother □ grandfather □ aunt □ uncle □ other relative □ roommate □ other **If other relation, please note:** | | |
| **Name:** | **Phone number:** | **Age:** |
| **Relationship to infant:** □ foster parent □ sibling □ grandmother □ grandfather □ aunt □ uncle □ other relative □ roommate □ other **If other relation, please note:** | | |
| **Name:** | **Phone number:** | **Age:** |
| **Relationship to infant:** □ foster parent □ sibling □ grandmother □ grandfather □ aunt □ uncle □ other relative □ roommate □ other **If other relation, please note:** | | |
| **Name:** | **Phone number:** | **Age:** |
| **Relationship to infant:** □ foster parent □ sibling □ grandmother □ grandfather □ aunt □ uncle □ other relative □ roommate □ other **If other relation, please note:** | | |

| Signatures: | |
|---|---|
| **Parent/caregiver:** | **Staff:** |