

**Hospital Referral
Substance Exposed (SE) Newborn / Postpartum Case Management (CM)**

To: _____ **Phone#:** _____ **Fax#:** _____
From: _____ **Date:** ____/____/____
Discharge Planner: _____ **Time:** _____
Phone#: _____

We are making the following postpartum referral:

- Mandatory Hospital SE Newborn referral /postpartum CM (Code of Va §32.1-127 B6) ***
- Other reason:** _____

Patient Information				
Name: _____				
Street Address: _____				
City: _____				
Zip: _____	Phone: _____	Other Phone: _____		
DOB: _____	Other contact: _____	Phone: _____		
Discharge Date: ____/____/____				
Child Information				
Name: _____		Gender: _____	Weight: _____	
Pre-term Delivery? Y N		Discharge Date: _____		
Delivery Date: ____/____/____		In NICU? Y N	Estimated Discharge Date : _____	
If still pregnant, Estimated Date Delivery: ____/____/____				
Reason for Referral / Supporting Information				
*Toxicology Results: Check Applicable Box	Mother		Child	
	Positive	Negative	Positive	Negative
Cocaine				
Cannabis				
Opioid				
Alcohol				
Methamphetamine				
Other substance:				
Other Indicators/ Concerns (Mother)	Circle Correct Answer			
Placental Abruption	Y	N		
Lack of prenatal care at 24 weeks or more	Y	N		
*Withdrawal symptoms/Vital signs	Y	N		
*Self-disclosure of use during pregnancy	Y	N		
History of substance abuse	Y	N		
Not bonding with newborn	Y	N		
Not parenting other children	Y	N		
Other Indicators/ Concerns (Newborn)				
*Withdrawal symptoms/Vital signs	Y	N		
*Fetal Alcohol Syndrome/Fetal Alcohol Effects	Y	N		
Additional Discharge Plan/Comments: 				

***Hospitals must also file a CPS report on suspected SE Newborns (Code of VA §63.2-1509)**

CSB referral made: Y N **To Whom:** _____ **Phone #:** _____
CPS report made: Y N **To Whom:** _____ **Phone #:** _____
Part C referral made: Y N **To Whom:** _____ **Phone #:** _____