



Plan of Safe Care Foster Family Care Plan

- | |
|---------------------------------------|
| <input type="checkbox"/> Kent |
| <input type="checkbox"/> Landmark |
| <input type="checkbox"/> Newport |
| <input type="checkbox"/> South County |
| <input type="checkbox"/> WIH |

Infant Name _____ DOB ____/____/____ MRN _____

The Plan of Safe Care – Foster Family Care Plan coordinates existing supports and provides referrals to new supports that may be helpful after an infant’s birth. The hospital treatment team is responsible for completing this form in consultation with the caregiver.

Check all applicable supports and new referrals for caregiver(s)						
Caregiver Supports	New Referral	Current	Discussed	N/A	Organization	Contact person (if applicable)
Safe Sleep Education			<input type="checkbox"/>			
Smoking Exposure Education			<input type="checkbox"/>	<input type="checkbox"/>		
Smoking Cessation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Fostering Support Group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Family Home Visiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Basic Needs (housing, food, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other (behavioral health, medical, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other (behavioral health, medical, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Check all applicable supports and new referrals for infant						
Infant Supports	New Referral	Current	Discussed	N/A	Organization	Contact person (if applicable)
Pediatrician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Skilled Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
First Connections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
WIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Brown Family Care F/U Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other (behavioral health, medical, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other (behavioral health, medical, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Plan of Safe Care was prompted by: Self-reported prenatal substance exposure Infant withdrawal signs
 Positive toxicology screen (infant/maternal) at, or following, delivery Fetal Alcohol Spectrum Disorder diagnosis

Prenatal Substance Exposure		Prenatal Substance Exposure	
Methadone	<input type="checkbox"/>	Illicit opioids:	<input type="checkbox"/>
Buprenorphine	<input type="checkbox"/>		
Opioids for pain	<input type="checkbox"/>	Other medications:	<input type="checkbox"/>
Nicotine/tobacco	<input type="checkbox"/>		
Nicotine replacement therapy	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>		
Alcohol	<input type="checkbox"/>		

Comments

Plan was reviewed with caregiver YES NO

Caregiver Signature **Date** **Attending Physician Signature** **Date**