

## NOTIFICATION OF SUBSTANCE-EXPOSED NEWBORN (SEN)

The completed form must be submitted as soon as reasonably possible and not later than 48 hours after the contact, examination, attention, treatment, or testing that prompted the notification to the local department of Social Services where the newborn's parent or caregiver intends to reside with the substance-exposed newborn. **This form does not exempt a reporter from making an oral notification to the Local Department of Social Services (LDSS) as Md. Code Ann. Fam. Law. § 5-704.2 requires a reporter to make an oral and a written notification to LDSS. \* = Required Field**

### Section I: SEN INFORMATION

\*Name and Address of Local Department of Social Services (LDSS): \_\_\_\_\_

\*Name of Person Making Report: \_\_\_\_\_ \*Position/Title: \_\_\_\_\_ \*Contact Number: \_\_\_\_\_

\*Name of Hospital/Birthing Center: \_\_\_\_\_

### Section II: NEWBORN'S REFERRAL INFORMATION

a. \*Name of Newborn: \_\_\_\_\_ b. \*Date of Birth (the newborn must be less than 30 days old) [M/D/YYYY]: \_\_\_\_\_

c. \*Weight (pounds and ounces in numeric form): \_\_\_\_\_ d. \*Gestational Age (type numeric form): \_\_\_\_\_

e. \*Newborn's Substance Exposure select all that apply:

- Category - OPIOIDS  Heroin/Schedule I  Hydrocodone/Schedule II  Buprenorphine/Schedule II  Morphine/Schedule II
- Fentanyl/Schedule II  Oxycodone/Schedule II  Oxycodone-Perocet/Schedule II  OxyContin/Schedule II  Codeine/Schedule II
- Methadone/Schedule II Category - STIMULANTS  Cocaine/Schedule II  Methamphetamine/Schedule II
- Methylphenidate (Ritalin)/Schedule II  Amphetamine/Schedule II  Adderall  Vyvanse
- Category - DEPRESSANTS  Benzodiazepine/Schedule IV  Valium  Xanax  Barbiturates  Alcohol
- Category - HALLUCINOGENS and OTHER COMPOUNDS  Marijuana/Schedule I  Amphetamine/Schedule I- Ecstasy  LSD/Schedule I
- Ketamine/Schedule III  Phencyclidine (PCP)/Schedule II  Other \_\_\_\_\_

e.1. Test administered to determine newborn's substance exposure: \_\_\_\_\_  
Specify Other \_\_\_\_\_

f. \*Newborn Affected by Substance Exposure: \_\_\_\_\_ g. \*Newborn Displays Effects of Fetal Alcohol Spectrum Disorder: \_\_\_\_\_

h. \*Newborn Withdrawal Symptoms Resulting From Prenatal Exposure: \_\_\_\_\_

h.1. If yes, select all withdrawal symptoms present select all that apply:

- Tremors  Irritability  Excessive Crying  Sleep Problems  Sweating  Sneezing  Yawning
- Fever or Unstable Temperature(s)  Excessive Weight Loss  Rapid Breathing  Nasal Stuffiness  High Pitched Crying  Seizures
- Hyperactive Reflexes  Poor Feeding  Excessive Sucking  Vomiting  Rapid Heart Rate  Other \_\_\_\_\_

Specify Other \_\_\_\_\_

i. \*Medication Treatment Required to Address Newborn's Withdrawal Symptoms: \_\_\_\_\_

i.1 If yes, indicate medication treatment and dosage (name of medication and prescribed dosage): \_\_\_\_\_

j. \*Neonatal Abstinence Syndrome (NAS) Diagnosis: \_\_\_\_\_

k. \*Medical condition or ongoing health conditions (type international classification of diseases ICD code and brief summary of newborns medical needs): \_\_\_\_\_

**l.** \*Newborn planned discharge date (Select a date/calendar): \_\_\_\_\_

**m.** \*Address where newborn can be seen (if hospital include the hospital name, address, unit, floor, and room number):  
\_\_\_\_\_

**n.** \*Transfer to a pediatric center/hospital required to address medical condition: \_\_\_\_\_

**n.1** \*If yes full name of hospital, hospital address and telephone number (include the specific unit providing care for newborn):  
\_\_\_\_\_

**o.** \*Address where newborn will reside upon discharge (full address to include city, state & zip code):  
\_\_\_\_\_

**p.** \*Name of the parent/s or caregiver newborn will reside with at discharge (type Full Name):  
\_\_\_\_\_

### Section III: PARENT/CAREGIVER INFORMATION

**a.** \*Mother's Name (type full name): \_\_\_\_\_

**b.** \*Date of Birth: (M/D/YYYY): \_\_\_\_\_

**c.** \*Address where mother will reside if different from newborn's address in Section II (full address to include city, state & zip code):  
\_\_\_\_\_

**d.** \*Mother's Phone Number (indicate if cell or home): \_\_\_\_\_

**d.1** \*Alternative or emergency contact number: \_\_\_\_\_

**e.** \*Father's Name (type full name): \_\_\_\_\_

**f.** \*Date of Birth (M/D/YYYY): \_\_\_\_\_

**g.** \*Address where father will reside if different from newborn's address in Section II (full address to include city, state & zip code):  
\_\_\_\_\_

**h.** \*Father's Phone Number (indicate if cell or home): \_\_\_\_\_

**h.1** \*Alternative or emergency contact number: \_\_\_\_\_

**i.** Alternative Caregiver's Name: \_\_\_\_\_

**j.** Date of Birth (M/D/YYYY): \_\_\_\_\_

**k.** Address where caregiver will reside if different from newborn's address in Section II (full address to include city, state & zip code):  
\_\_\_\_\_

**l.** Caregiver's Phone Number (indicate if cell or home): \_\_\_\_\_

### Section IV: REFERRAL INFORMATION

#### NEWBORN'S MOTHER

**a.** \*Prenatal Care Started: \_\_\_\_\_ **b.** Mother substance use select all that apply:

**Category - OPIOIDS**  Heroin/Schedule I  Hydrocodone/Schedule II  Buprenorphine/Schedule II  Morphine/Schedule II

Fentanyl/Schedule II  Oxycodone/Schedule II  Oxycodone-Percocet/Schedule II  OxyContin/Schedule II  Codeine/Schedule II

Methadone/Schedule II **Category - STIMULANTS**  Cocaine/Schedule II  Methamphetamine/Schedule II

Methylphenidate (Ritalin)/Schedule II  Amphetamine/Schedule II  Adderall  Vyvanse

**Category - DEPRESSANTS**  Benzodiazepine/Schedule IV  Valium  Xanax  Barbiturates  Alcohol

**Category - HALLUCINOGENS and OTHER COMPOUNDS**  Marijuana/Schedule I  Amphetamine/Schedule I- Ecstasy  LSD/Schedule I

Ketamine/Schedule III  Phencyclidine (PCP)/Schedule II  Other \_\_\_\_\_

**c.** \*Mother self-reported date of last substance use (select a date): \_\_\_\_\_

d. \*Mother self-reported current or past substance use treatment: \_\_\_\_\_

If yes, list treatment last received (include type of treatment i.e., medicated assisted treatment, residential, outpatient; name of treatment program; dates program attended):

**\*PRESCRIPTION VERIFICATION**

e. \*Mother self-reported controlled substance(s) prescribed: \_\_\_\_\_

f. \*Mother's prescription verified: \_\_\_\_\_

f.1. \*If no, reason prescription not verified (type a brief narrative):

g. \*Name of prescriber: \_\_\_\_\_ g.1. \*Telephone Number: \_\_\_\_\_

h. \*Reported indication for prescribed controlled substance (brief narrative to include name of substance prescribed, dosage, and compliance):

i. Current or past mental health services self-reported by mother: \_\_\_\_\_

j. Intellectual or Developmental Disability: \_\_\_\_\_

k. Mother identified social support: \_\_\_\_\_

l. Intimate Partner Violence self-reported by mother (current or past): \_\_\_\_\_

**NEWBORN'S FATHER**

m. Current or past substance use: \_\_\_\_\_

If yes, father substance use: select all that apply:

- Category - OPIOIDS**  Heroin/Schedule I  Hydrocodone/Schedule II  Buprenorphine/Schedule II  Morphine/Schedule II
- Fentanyl/Schedule II  Oxycodone/Schedule II  Oxycodone-Perocet/Schedule II  OxyContin/Schedule II  Codeine/Schedule II
- Methadone/Schedule II **Category - STIMULANTS**  Cocaine/Schedule II  Methamphetamine/Schedule II
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- Category - DEPRESSANTS**  Benzodiazepine/Schedule IV  Valium  Xanax  Barbiturates  Alcohol
- Category - HALLUCINOGENS and OTHER COMPOUNDS**  Marijuana/Schedule I  Amphetamine/Schedule I- Ecstasy  LSD/Schedule I
- Ketamine/Schedule III  Phencyclidine (PCP)/Schedule II  Other \_\_\_\_\_

n. Father self-reported date of last substance use (*select a date*): \_\_\_\_\_

o. Father self-reported current or past substance use treatment: \_\_\_\_\_

If yes, list treatment last received (*include type of treatment i.e., medicated assisted treatment, residential, outpatient; name of treatment program; dates program attended*):

p. Father self-reported controlled substance(s) prescribed: \_\_\_\_\_

q. Current or past mental health services self-reported by father: \_\_\_\_\_

r. Intellectual or Developmental Disability: \_\_\_\_\_

s. Father identified social support: \_\_\_\_\_

t. Intimate Partner Violence self-reported by father (*current or past*): \_\_\_\_\_

**Section V: ADDITIONAL REFERRAL INFORMATION**

a. \*Preparations for newborn identified by mother, father, or caregiver: This may include identifying newborn’s pediatrician, current newborn supplies such as car seat, crib bassinet, or etc.

a.1. \*Pediatrician’s contact information:

\*Full Name: \_\_\_\_\_

\*Telephone Number: \_\_\_\_\_

\*Full Address: \_\_\_\_\_

a.2. Next scheduled appointment date (if applicable) select a date: \_\_\_\_\_

**b.** \*Provide any additional information that would assist LDSS staff in assessing safety and risk and a developing Plan of Safe Care. This may include but not limited to the following: Mother, father, or caregiver current or past involvement with Department of Social Services (DSS); Referrals made by hospital staff for newborn, parent/s, or caregiver such as Infants & Toddlers, Healthy Families, Postpartum Infant Maternal Referral (Medicaid recipient only); Additional children (biological, non-biological) of mother, father, or caregiver in their household, under care of state agency or care of relative; Behavioral observations i.e. mother/father unable to respond to newborn in a manner consistent with newborn development, mother/father having inability to control his/her emotional or physical behavior.

\*Full name of LDSS staff person to whom oral report was made: \_\_\_\_\_

\_\_\_\_\_  
\*Reporter Signature

\*Date Completed (*select a date*): \_\_\_\_\_

\*Date Submitted to LDSS (*select a date*): \_\_\_\_\_

The completed form must be signed (electronic signature accepted) and emailed, faxed, or mailed to the LDSS where the newborn is expected to reside with email subject line title, "SEN Notification".

For a complete list of LDSS' CPS Screening and Intake contact numbers or email addresses visit  
<https://dhs.maryland.gov/child-protective-services/risk-of-harm/local-offices/>

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