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
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□ 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.) (10 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		
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 **(If infant has been placed with licensed foster parent, relative caregiver or a non-relative caregiver, complete this section)**		
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, upload report into REDCap.**		
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 □ Chewing tobacco	□	□	□
	□ Electronic nicotine products	□	□	□
□ **Alcohol use?**	N/A	□	□	□
□ **Marijuana use? If yes, what kind?** □ Flower □ Concentrates	□ Inhalation (smoking, vaping, dabbing) □ Oral (oils, tinctures, edibles) □ Topical (creams, oils)	□	□	□
Prescription drug use? □ Yes □ No **If yes, what kind?** □ Opioids, methadone, and/or fentanyl □ Buprenorphine (Subutex/Suboxone) □ Other (please specify):	□ Swallowed □ Snorted □ Injected	□	□	□
□ **Over the counter drug use?** 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	☐	☐		
Domestic Violence	☐	☐		
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
Which services were engaged?

Follow-up Plan:
Post-discharge family strengths and goals:
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:	**Age:**
Relationship to infant: □ foster parent □ sibling □ grandmother □ grandfather □ aunt □ uncle □ other relative □ roommate □ other **If other relation, please note:**	
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Relationship to infant: □ foster parent □ sibling □ grandmother □ grandfather □ aunt □ uncle □ other relative □ roommate □ other **If other relation, please note:**	
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Name:	**Age:**
Relationship to infant: □ foster parent □ sibling □ grandmother □ grandfather □ aunt □ uncle □ other relative □ roommate □ other **If other relation, please note:**	
Signatures:	
Parent/caregiver:	**Staff:**