



## CradleME Request PAGE 2

For Public Health Nursing fill out page 2 & send with Page 1 by FAX 207-287-4577 or e-mail [CradleME.MeCDC@maine.gov](mailto:CradleME.MeCDC@maine.gov)

**Suggested documents:** please include a release of information form along with supporting office notes or discharge summary for mom and baby when available. If any health concern is noted below, please consider checking off the public health nurse support box on page 1.

Prenatal Needs	Postpartum Needs	Infant or Child Needs
<b>Name:</b>	<b>Name:</b>	<b>Name:</b>
<b>DOB:</b>	<b>DOB:</b>	<b>DOB:</b>
<p>Check all that apply:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Accident or injury in pregnancy</li> <li><input type="checkbox"/> Behavioral / mental health-related risk factors Please specify: _____</li> <li><input type="checkbox"/> Child welfare involvement</li> <li><input type="checkbox"/> Emergency Department follow-up during pregnancy</li> <li><input type="checkbox"/> Missed prenatal visits or late onset of care</li> <li><input type="checkbox"/> Fetal surveillance that supplements care by OB provider</li> <li><input type="checkbox"/> Medications requiring nursing assessment of the medication regime (dose, side effects, compliance) and the condition for which it was prescribed.</li> <li>_____</li> <li><input type="checkbox"/> Chronic health condition</li> <li><input type="checkbox"/> Complications of pregnancy: Fetal or placental</li> <li><input type="checkbox"/> Complications of pregnancy: Maternal</li> <li><input type="checkbox"/> Developmental or physical disability</li> <li><input type="checkbox"/> Diabetes in pregnancy</li> <li><input type="checkbox"/> Hypertension disorders of pregnancy</li> <li><input type="checkbox"/> Multi-fetal gestation</li> <li><input type="checkbox"/> Preterm labor or contractions</li> <li><input type="checkbox"/> Substance Use Disorder</li> <li><input type="checkbox"/> Tobacco Use</li> <li><input type="checkbox"/> Marijuana/Cannabis use</li> <li><input type="checkbox"/> Alcohol use disorder</li> <li><input type="checkbox"/> Other health-related risk factors affecting pregnancy. Please specify:</li> <li><input type="checkbox"/> Psycho-social issues*, please specify:</li> </ul>	<p>Check all that apply:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Abnormal bleeding or discharge</li> <li><input type="checkbox"/> Behavioral / mental health-related risk factors Please specify: _____</li> <li><input type="checkbox"/> Child welfare involvement</li> <li><input type="checkbox"/> Chronic health condition</li> <li><input type="checkbox"/> Complications of labor, birth or postpartum</li> <li><input type="checkbox"/> Developmental or physical disability</li> <li><input type="checkbox"/> Substance Use Disorder</li> <li><input type="checkbox"/> Tobacco Use</li> <li><input type="checkbox"/> Marijuana/Cannabis use</li> <li><input type="checkbox"/> Alcohol Use Disorder</li> <li><input type="checkbox"/> Other Please specify:</li> <li><input type="checkbox"/> Psycho-social issues*, please specify:</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Plan of Safe Care Completed               <ul style="list-style-type: none"> <li><input type="checkbox"/> Substance Exposed/Affected Infant*</li> <li><input type="checkbox"/> Child welfare involvement</li> <li><input type="checkbox"/> FAS (Fetal Alcohol Syndrome)*</li> <li><input type="checkbox"/> Neonatal Abstinence Syndrome*</li> <li><input type="checkbox"/> NICU admission or discharge</li> </ul> </li> <li>Other health concerns, check all that apply:               <ul style="list-style-type: none"> <li><input type="checkbox"/> Breastfeeding</li> <li><input type="checkbox"/> Breast &amp; Bottle</li> <li><input type="checkbox"/> Bottle</li> <li><input type="checkbox"/> Birth Weight:</li> <li><input type="checkbox"/> Discharge Weight:</li> <li><input type="checkbox"/> Birth Defects that may impact feeding or development, or requiring specialized care*</li> <li><input type="checkbox"/> Birth injuries*</li> <li><input type="checkbox"/> Diagnosed with a disorder through newborn screening*</li> <li><input type="checkbox"/> Failure to thrive*</li> <li><input type="checkbox"/> Infant feeding difficulty with challenges (other than just breastfeeding) *</li> <li><input type="checkbox"/> Intrauterine growth restriction*</li> <li><input type="checkbox"/> Newborn extended stay (&gt;4 days)</li> <li><input type="checkbox"/> Prematurity &lt;29 weeks*</li> <li><input type="checkbox"/> Respiratory distress syndrome*</li> <li><input type="checkbox"/> Seizures*</li> <li><input type="checkbox"/> Other specific health conditions that require nursing assessment and follow up. Please specify:</li> </ul> </li> </ul> <p>*Is an existing condition of risk-automatically eligible for Early Intervention for ME-consider checking box on page 1</p>

### REFERRING ORGANIZATION: PLEASE COMPLETE

\*Organization: \_\_\_\_\_ \*Name: \_\_\_\_\_ \*Phone: \_\_\_\_\_

