

# Staffing Sheet

Staffing Date \_\_\_\_\_ Staffing Risk Level \_\_\_\_\_  
Client's Name \_\_\_\_\_ DOB \_\_\_\_\_ Location \_\_\_\_\_  
LMP \_\_\_\_\_ EDC \_\_\_\_\_ Weeks Pregnant \_\_\_\_\_  
Occupation \_\_\_\_\_ OB/GYN \_\_\_\_\_ Phone \_\_\_\_\_  
Other Children \_\_\_\_\_ DOB \_\_\_\_\_ Location \_\_\_\_\_  
\_\_\_\_\_ DOB \_\_\_\_\_ Location \_\_\_\_\_  
Methadone/Drug Abuse Hx \_\_\_\_\_

Tobacco Use \_\_\_\_\_ Alcohol Use \_\_\_\_\_  
Current Methadone Dose \_\_\_\_\_  
Current Methadone Prescriber \_\_\_\_\_ Phone \_\_\_\_\_  
Current Methadone Supplying Agency \_\_\_\_\_ Phone \_\_\_\_\_  
Cost to Client \_\_\_\_\_ Medicaid Y / N MU MMP Type \_\_\_\_\_  
Last UDS on Client Date \_\_\_\_\_ Results \_\_\_\_\_  
Agency \_\_\_\_\_  
Enrolled in HS/HF YES  NO  IC or IA Completed Y N  
Last Face to Face \_\_\_\_\_ Healthy Start Level (Circle One) 1 2 3  
HS/HF Case Manager \_\_\_\_\_ Phone \_\_\_\_\_  
Last HS/HF Meeting \_\_\_\_\_  
Clinical Dependency Evaluation Completed YES  NO  Date Evaluation Completed \_\_\_\_\_  
Recommendations \_\_\_\_\_

Out Patient  Day/Night  Residential Level (Circle One) I II III  
Treatment Start \_\_\_\_\_

Plan for Infant  Keep  Adoption  Foster Care  
Child Care Needs  YES  NO Follow-Up \_\_\_\_\_  
Support System Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Social Worker Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Pediatrician \_\_\_\_\_ Phone \_\_\_\_\_  
Other Services/Activities Contributing Toward Case Plan \_\_\_\_\_

Concerns \_\_\_\_\_

Actions \_\_\_\_\_

Breastfeeding \_\_\_\_\_  
Bottle \_\_\_\_\_  
Risk Reduction Evaluation \_\_\_\_\_  
HIV Status \_\_\_\_\_  
Hepatitis B Status \_\_\_\_\_

Consent on File  Yes  No Agencies included on form: \_\_\_\_\_  
HS Screen on File  Yes  No  
CMS Referral  Yes  No  
DCF Involved  Yes  No