Bridging Information and Resources to Transform Health for South Dakota parents

BIRTH-SD

BIRTH-SD-AIM Plan of Safe Care Guide

This form is meant to act as a guide for completing a plan of safe care for a family either during prenatal care or prior to discharge after birth. Please fill in as many fields as possible and provide this document to the family in order to help coordinate care and resources.

Date: _____

Plan Type:

Prenatal ☐ Postnatal (infant-focused) ☐ Postpartum (caregiver-focused) ☐

Patient Information:

Patient First Name _____ Patient Last Name _____ DOB_____

Email Address _____ Current Address _____

City _____ State _____ Zip Code _____ County _____

Infant Information:

Infant Name _____ Infant Sex _____ DOB _____

Household Members:

Name	Age	Relationship to Infant

Family Supports, Strengths, and Resources:

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Needs, Risks, Interventions – Adult/Caregiver

Adult/Caregiver Needs	Referral Needed (Yes/No)	Need Status (Need not identified, Referral made, Services already established, Need resolved)	Organization/Contact Person Providing the Service
Substance Use Treatment (includes MAT)	Select	Select	
Mental Health Treatment	Select	Select	
Medical/Physical Health Care (vision, dental, medical)	Select	Select	
Medical Coverage (vision, dental, medical)	Select	Select	
Family Planning (contraceptive methods and planning)	Select	Select	
Smoking Cessation	Select	Select	
Peer Recovery Support (certified peers, community-based groups, etc.)	Select	Select	
Parenting Skills & Education	Select	Select	
Home Visiting	Select	Select	
Healthcare (medical/dental coverage)	Select	Select	
Financial Assistance	Select	Select	
Food Assistance	Select	Select	
Infant Feeding/WIC	Select	Select	
Breastfeeding Support	Select	Select	
Housing Assistance	Select	Select	
Childcare	Select	Select	

Employment/Training	Select	Select	
Transportation	Select	Select	
Other: _____	Select	Select	
Other: _____	Select	Select	
Other: _____	Select	Select	

Needs, Risks and Interventions – Infant

Infant Needs	Referral Needed (Yes/No)	Need Status (Need not identified, Referral made, Services already established, Need resolved)	Organization/Contact Person Providing the Service
Exposure/Withdrawal Needs and Intervention	Select	Select	
Developmental Screenings and Interventions	Select	Select	
Other Medical/Physical Health Needs	Select	Select	
Infant Feeding/WIC	Select	Select	
Safe Sleep Practices	Select	Select	
Healthcare Coverage	Select	Select	
Childcare	Select	Select	
Child Clothing	Select	Select	
Basic Needs (diapers, crib, car seat)	Select	Select	
Other: _____	Select	Select	
Other: _____	Select	Select	
Other: _____	Select	Select	

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Plan of Safe Care Participant Signatures		
I understand the purpose of this plan of safe care, feel confident I can access the specified resources, and have no further questions for the provider filling this document out at this time. I understand this this file may be placed in my medical record in case external agencies require proof that this plan was made in the future and so I may request a copy in the future if it is lost.		
Patient Name:	Patient Signature:	Date:
I am confident that the patient understands this plan of safe care and that all necessary components have been addressed. I have provided the patient a copy and will place an additional copy in their medical record in case external agencies require proof that this plan was made or the patient requests an additional copy be made in the future.		
Provider Name:	Provider Signature:	Date:
Provider Phone Number:	Provider Clinic Location:	

Disclaimer: Plan of Safe Care document was mirrored after the Indiana Plan of Safe Care document found on their Perinatal Quality Collaborative's website