



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 CHILDREN'S DIVISION
 NEWBORN CRISIS ASSESSMENT TOOL (NCAT)

CASE DATA		
Referral Number	County	Drug Involved <input type="checkbox"/> Non-Drug Involved <input type="checkbox"/>
Case Name		Children's Service Worker
Child's Information		
Infant's Name		DOB
Birth Weight	Gestational Age	Discharge Date
Parent's Information		
Mother's Name		Father's Name
Is Father on Birth Certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, was an affidavit signed by the alleged father? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Comments:		
PRIOR HISTORY		
<input type="checkbox"/> No history <input type="checkbox"/> Prior Newborn Crisis Assessment on sibling(s) <input type="checkbox"/> Parents/caregivers have a history of abuse/neglect or previous CD case with protective services <input type="checkbox"/> History of children out of the home with relatives, friends, or foster care <input type="checkbox"/> Protective services case is currently open <input type="checkbox"/> CD investigation/assessment currently pending <input type="checkbox"/> Siblings currently placed out of the home <input type="checkbox"/> Siblings currently under court jurisdiction <input type="checkbox"/> Siblings have been Termination of Parental Rights <input type="checkbox"/> History of domestic violence <input type="checkbox"/> Prior history of safe sleep related incident, death of another child in the home or serious injury to another child in the home.		
Summary/Comments:		
MEDICAL DOCUMENTATION		
HOSPITAL	PHYSICIAN	PHONE
HOSPITAL CONTACT PERSON		PHONE
PRENATAL CARE		
<input type="checkbox"/> Regular prenatal care Prenatal Care Provider: _____ <input type="checkbox"/> Inconsistent, late, or no prenatal care <input type="checkbox"/> Prenatal drug use <input type="checkbox"/> Unwanted pregnancy		
Comments:		

Pregnancy Complications; <input type="checkbox"/> Yes <input type="checkbox"/> No			
Describe:			
TOXICOLOGY AT BIRTH			
Mom Urine Drug Screen	Infant Urine Drug Screen	Infant Meconium Drug Screen	Cord Drug Screen
<input type="checkbox"/> Pending <input type="checkbox"/> Not done <input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Pending <input type="checkbox"/> Not done <input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Pending <input type="checkbox"/> Not done <input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Pending <input type="checkbox"/> Not done <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Substances	Substances	Substances	Substances
Substances	Substances	Substances	Substances
Substances	Substances	Substances	Substances
Has the infant been identified as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or "a Fetal Alcohol Spectrum Disorder"? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Withdrawal Symptoms: <input type="checkbox"/> None <input type="checkbox"/> Seizures/abnormal neurological findings <input type="checkbox"/> Uncontrolled crying, increased irritability, trembling <input type="checkbox"/> Abnormal GI, persistent feeding problems, watery stools <input type="checkbox"/> Mild sensory deficit, increased or decreased activity <input type="checkbox"/> Requires medication for withdrawal			
Comments:			
<p>*Note: When determining if an infant has been "affected" by substance use or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, Children's Division staff shall assess if the child's physical, mental, or general well-being is affected by the use of substances by the parent/caretaker and a Plan of Safe Care is needed.</p>			
HEALTH CARE NEEDS OF INFANT			
Special Health Care Needs of the Infant: <input type="checkbox"/> None <input type="checkbox"/> Infant on monitor, apnea <input type="checkbox"/> Low birth weight (below 2400 grams or 5 lbs) <input type="checkbox"/> Frequent medical follow-up needed <input type="checkbox"/> Special feedings needed <input type="checkbox"/> Special home care/treatment for infant			
General Health Care Needs of the Infant:			
<input type="checkbox"/> Child has an identified pediatrician/primary care physician (PCP)			
Name of Pediatrician/PCP or NA if none identified at this time			
<input type="checkbox"/> Child has medical coverage, i.e. Medicaid/insurance,			
Type of coverage or NA if no coverage at this time			
Comments:			
BEHAVIOR ASSOCIATED WITH DRUG AND ALCOHOL USE OF PARENT(S)			

- No observed or known behaviors associated with drug and alcohol use
- Parent/caregiver admits to alcohol and/or drug use and is participating in a treatment program
- Evidence of drug/alcohol use and is not participating in a treatment program
- Prior treatment for drug/alcohol use
- Sibling(s) exposed to drugs or alcohol in utero
- Chemical use poses risk to family's financial resources and affects ability to meet basic need of family
- Friends or family members appear under the influence of drugs or alcohol
- Drugs sold, used or made in the home

What substance use worries exist?

What is or has been successful in regard to treating your substance use?

What support do you need to help you with your substance use?

Scaling: On a scale of 0 to 10 where 10 is your substance use does not affect your ability to parent your infant and 0 you do not have the ability to parent your infant based on your substance use. ___

What supports could be provided for you to increase your number?

MENTAL HEALTH OF PARENT(S)

- No known mental health needs
- Currently receiving mental health services
- Postpartum Depression
- Currently receiving physician assisted medication management for mental health needs
- History of suicide attempts
- Currently making suicidal gestures
- Chronic emotional, problems which impair ability to provide minimal care or supervision to infant
- Currently threatening to harm or actually harming the child
- Inability to function independently
- Not oriented to person, place, time
- Evasive, verbally hostile or physically assaultive/threatening to service provider
- Low cognitive functioning that would affect parent's ability to take care of infant

What mental health worries exist?

What is or has been successful in regard to treating your mental health needs?

What supports do you need to assist you with your mental health needs?

Scaling: On a scale from 0 to 10, where 10 is your mental health needs do not affect your ability to parent and 0 you do not have the ability to parent your children based on your mental health needs. __

What supports do you need to increase your number?

Domestic Violence reported in the household: Yes No
Comments:

ATTACHMENT AND BONDING

What are you worried about in regard to parenting your infant?

What are you excited about in regard to parenting your infant?

What support do you need to help you parent your infant?

Observations of parent/child interaction and bonding:

Scaling: On a scale of 0 to 10, where 10 is you have all the supports you need and feel prepared to parent your infant and 0 you do not have any supports and do not feel prepared to parent our infant. __

What supports could be provided to increase your number?

ASSESSMENT OF OTHER CHILDREN IN THE HOME

- No other children residing in the home
- Parent(s) meeting mental health needs of other children in the home
- Parent(s) meeting educational needs of other children in the home
- Parent(s) meeting medical needs of other children in the home
- Parent(s) meeting physical needs of other children in the home, i.e., food, clothing, safe shelter, appropriate sleeping arrangements

Summary of observations of other children in the home:

OBSERVATIONS OF INFANT'S HOME ENVIRONMENT

- Observed supply of baby formula Mother is breastfeeding.
- Observed crib or bassinet for infant
- Observed car seat for the infant
- Observed baby supplies for infant, i.e. diapers, bottles, wipes, clothing
- Observed food for others living in the home
- Observed operable plumbing and electricity/heating in the home
- Home free of physical or environmental hazards that might be dangerous for the infant
- Home free of infestations of insects or rodents

Describe infant's sleeping environment:

- Parent(s) has been given the Safe Sleep Flyer (CD 278) and worker explained the importance of a safe sleeping environment for the infant.
- Parent has acknowledged and signed that they have received and understand the Safe Sleep Flyer (CD278).
- Referrals made to Family Support Division, WIC, First Steps, Home Visiting, Parents As Teachers, or other community agency as needed.

Comments:

PLAN OF SAFE CARE

Was a Plan of Safe Care developed with the family? Yes No N/A

Was a referral(s) made for appropriate services for the affected child or family member/caregiver? Yes No N/A

Describe services referred:

A Plan of Safe Care should be inclusive of the following:

- Parents' or infant's treatment needs;
- Other identified needs that are not determined to be immediate safety concerns;
- Involvement of systems outside of child welfare
- A plan that is able to continue beyond the child welfare assessment if a case is not opened for further services.

Plan of Safe Care:

SIGNATURES		
CHILDREN'S SERVICE WORKER >		DATE
SUPERVISOR>		DATE