MY FAMILY WELLNESS PLAN*

*ALSO KNOWN AS: PLAN OF SAFE CARE (POSC)

COUNTY OF ORANGE

My Family Wellness Plan

Expecting a new baby can be exciting, but it can also be a challenging time especially for those struggling with mental health and/or substance use. Individuals may feel alone during this time of uncertainty and can benefit from additional resources. The Family Wellness Plan (FWP) covers various topics, but it is unique to you and your situation. We recognize your individuality and empower you to decide what sections you want to complete. The appendix may be particularly helpful if you struggle with mental health, alcohol or substance use.

This Family Wellness Plan will help those working with you understand your plans for pregnancy, delivery and parenthood.

This plan will help you:

- Make decisions on how to care for yourself, your baby and your family
- Communicate important information about yourself to your providers
- Identify the people in your support system who can help
- Gather information about resources that you need

This plan belongs to:

_____

Date I started My Plan: _____

Baby Due Date/Delivery Date: _____

MY FAMILY WELLNESS PLAN

ABOUT ME

FULL NAME: **BIRTHDATE:**

CURRENT LIVING ARRANGEMENT

☐ House or Apartment ☐ Homeless ☐ Emergency Shelter
☐ Living with Relatives/Friends ☐ Residential Treatment Center ☐ Correctional Facility
☐ Other:

EMERGENCY CONTACT INFORMATION

Name: Relationship: Phone:

Email:

MY STRENGTHS

What areas am I doing well in?

MY SUPPORT SYSTEM

Name	Contact (phone/email)	Spouse/Partner	Family	Friend	Counselor	Faith Community	Recovery Community	Child care	Peer Mentor	Other	Role

MY GOALS

What areas do I want to work on?

MY FAMILY WELLNESS PLAN

HOUSEHOLD – WHO LIVES WITH ME?

Name	Relationship	Age		Name	Relationship	Age

PARTNER'S INFORMATION (if applicable)

Name: Birthdate: Phone:

Address:

Will partner be involved in infant's life? ☐ Yes ☐ No ☐ Unsure

Comments:

MEDICAL INFORMATION

MEDICAL AND MENTAL HEALTH CONDITIONS REQUIRING ONGOING CARE
(Information about my health I would like my providers to know)

PREVIOUS PREGNANCIES

Total Number of Pregnancies: _____

Number of Live Births: _____

Describe any complications during prior pregnancies:

ALCOHOL AND OTHER SUBSTANCE USE HISTORY
(Information about my health I would like my providers to know)

CURRENT MEDICATIONS

Medications	Dose	Prescriber	Reason for Use/Other Notes

Reminder: there are additional tools in the appendix that may be helpful if applicable

MY NEEDS & REFERRALS (page 1)

Resource, Service, Program	Currently Receiving	Need	Date New Referral Placed	Referral Contact Information
BASIC / GENERAL NEEDS				
CalWORKs				
Education/Vocational Training				
Employment/Source of Income				
Food/CalFresh				
Housing				
Immigration/Refugee Services				
Legal Assistance				
Transportation				
Women Infants Children (WIC)				
Other:				
SAFETY				
Car Seat				
Safe Sleep Education				
Safeguarding My Family				
Unsafe Home Environment (lead, non-working smoke alarms, exposed wires, etc.)				
Other:				
BEHAVIORAL HEALTH				
Counseling				
Peer Support				
Other:				
SUBSTANCE USE				
Counseling				
MAT (Medication-Assisted Treatment)				
Outpatient Program				
Peer Support				
Recovery Group (12 Step, AA)				
Residential Program				
Smoking Cessation				
Substance Use Testing				
Other:				

MY FAMILY WELLNESS PLAN

MY NEEDS & REFERRALS (page 2)

Resource, Service, Program	Currently Receiving	Need	Date New Referral Placed	Referral Contact Information
PHYSICAL HEALTH				
Dentist				
Medical/Primary Care Provider				
OBGYN/Prenatal Care Provider				
Other:				
PARENTING & FAMILY EDUCATION/SUPPORT				
Birth Plan				
Bonding/Attachment				
Breastfeeding Support				
Child care				
Family Resource Center (FRC)				
Home Visiting				
Infant Development				
Nutrition Education				
Parenting/Caring for Baby Class				
Other:				
INFANT				
Developmental Screening				
Healthy Steps				
Home Visiting				
Pediatrician or Primary Care				
Women Infants Children (WIC)				
Other:				
Infant Supplies/Materials				
Bottles & Pacifiers				
Breast pump				
Clothing				
Crib/Safe Sleep Environment				
Diapers & Wipes				
Infant Formula				
Stroller				
Other:				
OTHER NEEDS/COMMENTS:				

MY PLAN AT HOME

LIVING & SLEEPING ARRANGEMENTS

What are my planned living arrangements?

What are the planned sleeping arrangements?

Where will infant sleep?

☐ Crib or Bassinet ☐ Sharing a bed with others ☐ Other, specify: _____

CHILD CARE PLANS

Child Care Name	Contact Number	Relationship (if applicable)

RELAPSE PREVENTION PLAN

A safe caregiver is a person you choose to leave your baby with in case of a relapse. A safe caregiver is patient with your baby, has a safe place for your baby to sleep, and should not have a history of violence or current drug/alcohol misuse.

I have spoken to these people and if I relapse, they are a safe caregiver:

Safe Caregiver Name	Contact Number	Relationship

NALOXONE (OPIOID REVERSAL MEDICATION) (Please check all that apply)

☐ I have Naloxone (opioid overdose reversal drug), and I know how to use it.
☐ I have a support person who has Naloxone (opioid overdose drug) and knows how to use it.

Comments:

MY FAMILY WELLNESS PLAN

DELIVERY & INFANT MEDICAL INFORMATION

DELIVERY INFORMATION

Delivery Date:

Hospital Name & Location:

Infant Name:

Mother's Hospital Record Number:

Infant's Hospital Record Number:

INFANT'S PRIMARY CARE PHYSICIAN INFORMATION (PCP)

PCP Name:

PCP Location (city):

PCP Phone:

INFANT OTHER INFORMATION (if applicable)

Developmental Needs:

Other Medical Conditions:

Comments:

INFANT'S BIOLOGICAL FATHER

Information about infant's biological father I want to share:

Is infant's biological father involved in infant's life?

INFANT'S SUBSTANCE SCREENING & TREATMENTS GIVEN

	Positive	Negative	Pending	Not Completed
Blood				
Meconium				
Urine				

Was a Fetal Alcohol Syndrome (FAS) screening conducted?

☐ Yes ☐ No

FAS Screening Result:

Withdrawal Symptoms:
(check all that apply)

- ☐ High Pitched Cry
- ☐ Sleep Disturbance
- ☐ Tremors
- ☐ Respiratory Issues
- ☐ Poor Feeding
- ☐ Vomiting
- ☐ Loose Stools
- ☐ Increased Muscle Tone

Finnegan/NAS Score:

Treatments Given for Withdrawal:

Reminder: there are additional tools in the appendix that may be helpful if applicable

MY PROVIDERS

This lists the contact information for providers and individuals who are collaborating with me on my Family Wellness Plan. *An optional column is provided if I want to use that to keep track of when I show my Family Wellness Plan to them.*

OBGYN/Prenatal Care Provider Name	Facility Location (City)	Phone/Email	FWP shared
Hospital	Facility Location (City)	Phone/Email	FWP shared
MOTHER'S PCP Name	Facility Location (City)	Phone/Email	FWP shared
INFANT'S PCP Name	Facility Location (City)	Phone/Email	FWP shared
OTHER PROVIDER(S) NAME	**Facility Location (City)**	**Phone/Email**	**FWP shared**

MY PLEDGE OF COMMITMENT

I am dedicated and devoted to preserving my family. My signature below acknowledges the following:

- I have been provided information regarding the purpose of the Family Wellness Plan (FWP).
- I understand that the FWP is developed for and by me with the support of my providers.
- I know that I can update the plan at any time and can use it as a tool to support me and my family in coordinating supportive services.
- I am encouraged to share my Family Wellness Plan with my providers and others. I can also choose not to share it.

Printed Full Name (Parent/Caregiver) _____ Signature _____ Date _____

The Family Wellness Plan (FWP) was completed with an interpreter: ☐ Yes ☐ No

APPENDIX

The following sections in the Appendix may be helpful for some clients. Please offer only those that are applicable and of interest to the client.

MY FAMILY WELLNESS PLAN

APPENDIX

MY SCREENING RESULTS

(Information about my health I would like my providers to know)

	Enter Score under the Screening Test Type					
Date Screened	**PHQ-9**	**EPDS**	**GAD-7**	**IPV**	**ACEs**	**Screened by**

Date Screened	**Other Screening Tests (if applicable)** Enter Name of Test & Score	**Screened by**

SUBSTANCE USE

(Information I would like my providers to know)

	Substance Used *Before* Pregnancy		**Substance Used *During* Pregnancy**	**Confirmed Toxicology Screen**		**Notes**
				Yes	**No**	
	Alcohol		Alcohol			
	Barbiturates		Barbiturates			
	Benzodiazepines		Benzodiazepines			
	Cannabinoids (Marijuana)		Cannabinoids (Marijuana)			
	Cocaine		Cocaine			
	Codeine		Codeine			
	Crack Cocaine		Crack Cocaine			
	Ecstasy		Ecstasy			
	Fentanyl		Fentanyl			
	Heroin		Heroin			
	Hydrocodone (Vicodin)		Hydrocodone (Vicodin)			
	Methadone		Methadone			
	Methamphetamine		Methamphetamine			
	Opiates		Opiates			
	Oxycodone		Oxycodone			
	Xanax		Xanax			
	Other:		Other:			

CHILD PROTECTIVE SERVICES (CPS) INFORMATION (if applicable)

CURRENT CPS INVOLVEMENT (if applicable)
(Information I would like my providers to know)

CPS Staff Name:	Staff Phone:	Case Opened on:
Other information I would like my providers to know:		

PREVIOUS CPS INVOLVEMENT (if applicable)
(Information I would like my providers to know)

Date	Incident	Outcome
Other information I would like my providers to know:		