

Sample Peripartum Checklist for Patients with SUD

Patient Name:
 Patient DOB:
 Patient Contact Information:
 Emergency Contact Information:

Patient EDD:

Outpatient Care Team

Primary OB:
 Primary OB Contact Information (e.g. phone number, fax):

Primary Social Worker/Case Manager:
 Primary Social Worker/Case Manager (e.g. phone number, fax):

If relevant:

MAT Provider/Facility:
 MAT Provider/Facility (e.g. phone number, fax):
 Current MAT Treatment and Dose: _____ as of _____ (MM/DD/YY)

Other SUD Treatment Provider/Facility:
 Other SUD Treatment Provider/Facility (e.g. phone number, fax):

Behavioral Health Treatment Provider/Facility:
 Behavioral Health Provider/Facility (e.g. phone number, fax):

Birth Support Individuals (e.g. family, doula):
 Birth Support Individuals' Contact Information:

Other: _____
 Other: _____

Labor & Delivery Considerations

Anticipated Delivery Hospital:
 Labor and Delivery Tour Date/Time:

Anticipated Mode of Delivery: [] Vaginal [] Cesarean

Desired MOC:
 If desired MOC is permanent sterilization, location and date California State signed:

Pain Control Considerations

If relevant, Anesthesia Provider Consult Date/Time/Location:

Anesthetic Options	Medical Recommendations			Patient Preferences			Comments
	Contraindicated	Use with Caution	Recommended	Open/Desires	Declines	Undecided	
Nitrous oxide							
Opioids							
Local Anesthesia							
Neuroaxial anesthesia							
NSAIDs							
Acetaminophen							
Adjust MAT (e.g. divide dose, increase)							
Other							
Other							

Additional Recommendations/Comments:

Newborn Care Considerations

If relevant, Neonatology Provider Consult Date/Time/Location:

Recommendations/Comments:

Lactation Considerations

If relevant, Lactation Consult Date/Time/Location:

Planned Method of Feeding:

Recommendations/Comments: