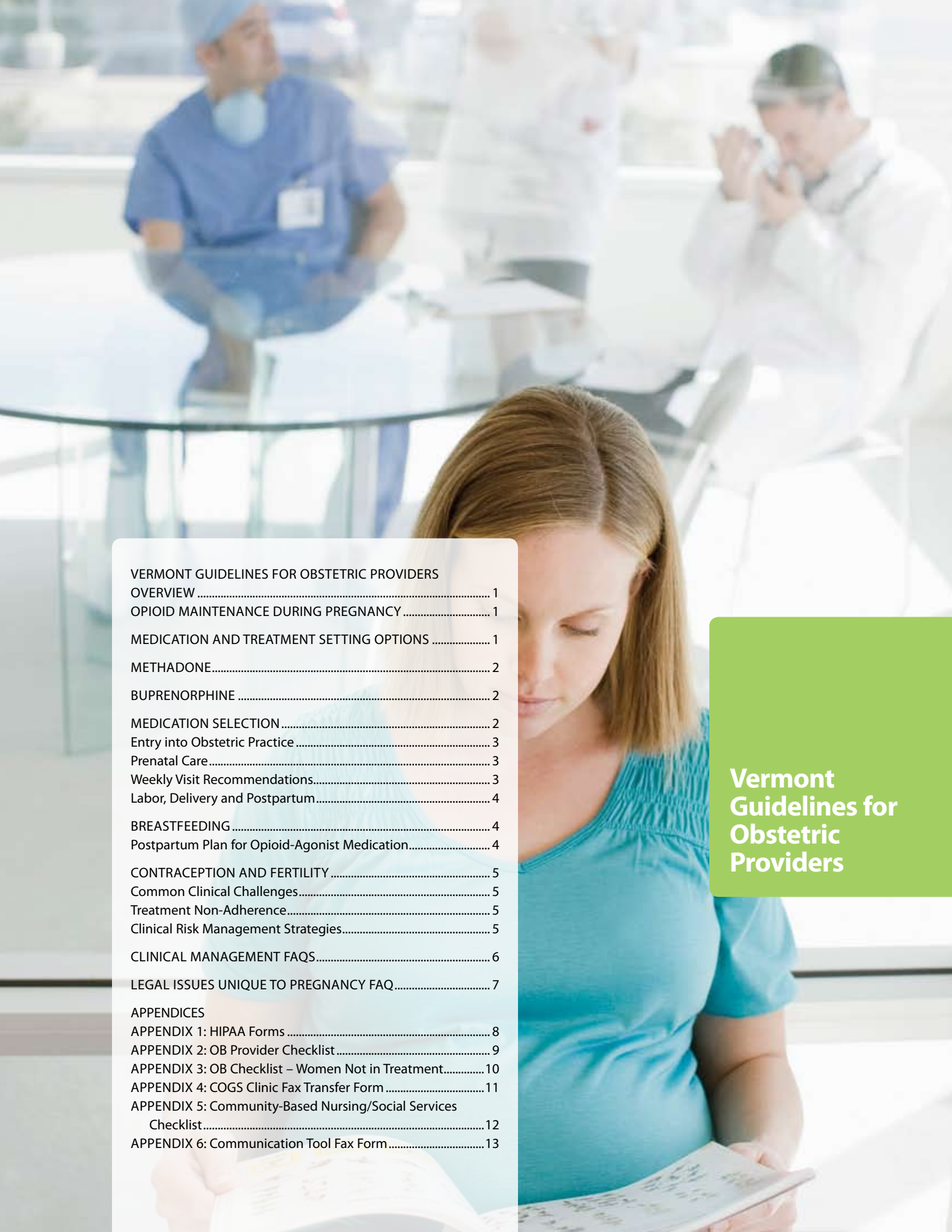
Vermont Guidelines for Obstetric Providers



Vermont Guidelines for Obstetric Providers

PURPOSE/DISCLAIMER

The Vermont Guidelines for Obstetric Providers were created to provide Vermont practitioners with a consolidated set of recommendations for the management of opioid dependence during pregnancy. The content of these guidelines is intended to complement standard medical care, the *Vermont Buprenorphine Practice Guidelines*, and other resources available through the American College of Obstetrics and Gynecology and Substance Abuse and Mental Health Services Administration (www.samhsa.gov) and Community-based Substance Abuse Treatment (www.csat.samhsa.gov).

These guidelines are not intended as requirements for practitioners. They should not be considered as medical advice.

ACKNOWLEDGEMENTS

The Vermont Guidelines for the *Treatment of Opioid Dependence in Pregnancy* are a collaborative effort of the Vermont Department of Health, Division of Alcohol and Substance Abuse Programs (VDH/ADAP) and the Department of Vermont Health Access (DVHA), with the guidance of local treatment providers. Many people contributed to developing these guidelines. Special thanks go to the following individuals:

John R. Brooklyn, MD
Barbara Cimaglio
Peter Lee
Todd W. Mandell, MD
Wendy Davis, MD
Vicki Loner
Jerilyn Metayer, RN
Anne Johnston, MD
Miriam Sheehey, RN
Nancy Lefebvre, RN
Marjorie Meyer, MD
Eleanor Capeless, MD

Vermont Guidelines for Obstetric Providers Overview

OPIOID MAINTENANCE DURING PREGNANCY

Opioid addiction is a chronic, relapsing disease. Acute opioid withdrawal is physiologically stressful, characterized by profound activation of the sympathetic nervous system with hypertension, tachycardia, and gastrointestinal symptoms. In the 1970s, a series of case reports and animal studies reported stillbirth and meconium aspiration when patients presented late in gestation in acute opioid withdrawal. Coincident with these reports, randomized trials in the general opioid dependent population demonstrated that methadone maintenance decreased opioid craving and allowed rehabilitation more effectively than acute withdrawal. As methadone maintenance for the treatment of opioid dependence became accepted as appropriate medical therapy, the use of methadone during pregnancy to prevent maternal (and fetal) withdrawal was examined. Methadone maintenance during pregnancy improved prenatal care, reduced illicit drug use, and minimized the risk of fetal *in utero* withdrawal. These demonstrated benefits led to the current recommendation for opioid-agonist maintenance for opioid dependent women during pregnancy.

MEDICATION AND TREATMENT SETTING OPTIONS

Treatment with an opioid-agonist improves pregnancy outcomes for opioid dependent women. The best outcomes are observed when women are enrolled in a comprehensive treatment program. The overarching goals of therapy for opioid dependence during pregnancy is to provide medical support to prevent withdrawal during pregnancy, minimize fetal exposure to illicit substances, and engage the mother as a leader in her recovery. Such engagement provides her the opportunity to receive both medical and ancillary services which will allow her to successfully parent her child. Recognizing that engagement into a comprehensive treatment program can be a gradual process, medication providers may face the difficult task of distinguishing the patient that needs a bit more time to become engaged in a treatment plan from the patient that is not ready for treatment. Assessment of treatment progression over some weeks may be needed.

GREATEST BENEFIT — **GREATEST RISK**

Comprehensive treatment program opioid-agonist therapy (methadone or buprenorphine) **OPTIMAL TREATMENT**	Buprenorphine without counseling; no illicit use	Methadone or buprenorphine with continued other illicit substance use	Continued illicit drug use with no treatment

Office-based therapy during pregnancy favors the patient that is highly motivated to recover and parent. Such women usually agree to substance abuse counseling and the assistance of community-based nursing to assist in recovery. Patients unwilling to engage these services may not be optimal candidates for office-based therapy and may benefit from the structure of a methadone program or residential treatment before proceeding to office-based therapy. Inclusion of substance abuse counseling and wrap-around services should be strongly encouraged for all patients, as medication alone is not sufficient for optimal pregnancy and parenting outcomes.

The decision regarding the most appropriate medication should be made jointly with the opioid-agonist provider, the obstetrician, and the patient. Women that are pregnant but are not candidates for office-based therapy should be referred to a methadone treatment center (Chittenden Center or BAART). An alternative is a residential program with reassessment for office-based therapy following successful completion of the residential treatment program.

Methadone: Opiate Program Center Based Treatment

Methadone is a pure mu opioid-agonist with a long half life (24 hours) which allows for daily dosing. Methadone is the medication of choice for treatment during pregnancy, owing to the simple fact that there are more data regarding neonatal outcomes following *in utero* exposure. It is a pregnancy category C drug and is not specifically approved for treatment of opioid dependence during pregnancy by the FDA, despite widespread recommendations as the medication of choice in pregnancy. Initiating or switching treatment to methadone should be offered to all opiate dependent pregnant patients.

Methadone for the treatment of opioid dependence is available only through opioid treatment centers. In Vermont, these centers provide medical screening and substance abuse counseling, including a full social assessment. Provision of these ancillary services has been demonstrated to improve retention in treatment and treatment outcomes.

Pregnant women are a high priority for treatment with methadone and will automatically be enrolled in a treatment program, despite long waiting lists for other patients. In Vermont, the major barriers to methadone treatment are the restricted daily dosing times and the travel time that is often needed. These issues are particularly difficult for women in school, working, with small children at home, and those that live a distance from a treatment center. Access to medication and ability to realistically comply with a treatment program can be considered in the overall decision regarding medication choice.

Buprenorphine: Office-Based Medication-Assisted Treatment

Buprenorphine is a partial mu opioid-agonist approved for the treatment of opioid dependence. Unlike methadone, buprenorphine is prescribed in medical offices rather than at licensed clinics. The *Vermont Buprenorphine Practice Guidelines* outline the background of office-based medication-assisted therapies and guidance for prescribers on the management of opioid dependent patients. Brand names for buprenorphine include Suboxone, which is a buprenorphine/naloxone combination and Subutex, which is buprenorphine alone.

Small cohort studies have found buprenorphine to be safe and effective in the treatment of opioid dependence during pregnancy. However, because it is a relatively new medication, long term outcome data of neonates exposed to buprenorphine *in utero* are lacking and patients seeking treatment should be informed of this. Nonetheless, risk/benefit may favor buprenorphine if the patient is otherwise a candidate for office-based therapy and there are barriers that preclude her attending a methadone program. The data suggest that treatment with buprenorphine provides better outcomes for mother and newborn compared to no treatment.

Candidates for buprenorphine are women that are stable on buprenorphine prior to pregnancy or those unable to attend a methadone treatment center AND are otherwise candidates for office-based therapy. Pregnancy does NOT make women automatically candidates for office-based therapy with buprenorphine, even if that is the only medication available in the community. Engagement in counseling and other services is vital during pregnancy and recovery for successful postpartum transition. Some women may benefit from residential treatment with office-based therapy following stabilization.

MEDICATION SELECTION

Please see the *Vermont Buprenorphine Practice Guidelines* for detailed information regarding the choice of medication and how to determine whether a patient, irrespective of pregnancy issues, is a candidate for office-based treatment.

Choosing the best medication for pregnancy is a discussion ultimately best suited to the medication provider and the patient. Recognizing many pregnant patients will look to their obstetric care provider before initiating medication, it may be helpful for the medication provider and obstetric provider to discuss the plan before presenting the final decision to the patient.

Methadone is the medication of choice due to the long term neonatal outcome data. Buprenorphine is a reasonable alternative in select patients. The discussion and decision for medication should be reviewed with the patient and documented in the chart. Please see *Appendix 2* in the Vermont Guidelines for Medication-Assisted Treatment (MAT) for Pregnant Women for a sample Patient Treatment Information sheet regarding medication during pregnancy, which can be reviewed with the patient.

For patients that are not optimal candidates for buprenorphine when methadone is not available, a step wise approach of initiation with buprenorphine with close follow-

up could be considered. In these instances, buprenorphine with very close and frequent follow-up could be considered with initiation of medication and counseling. Residential treatment or methadone could be considered for difficulty in buprenorphine treatment adherence.

If you are uncertain about the optimal medication for a pregnant patient, Fletcher Allen Health Care Comprehensive Obstetrics and Gynecology Clinic or Neonatology Service can assist in this decision making process and provide care to any opioid dependent patient.

The Fletcher Allen Comprehensive Obstetric Clinic is available to treat any opioid dependent women during pregnancy. (See *Appendix 6* for referral forms).

Entry into Obstetric Practice:

Prior to accepting patients maintained on methadone or buprenorphine into your obstetric practice, establish within your community of providers that appropriate training and resources are available for newborn assessment and treatment. A plan with pediatrics should be established for newborns that require medication for neonatal abstinence. (Refer to the Management of Neonatal Opioid Withdrawal section.)

If local care is not available, develop a clear process by which early antenatal care can be provided in your community with planned transition late in gestation to an obstetric service in a hospital with the ability to care for the opioid-exposed neonate. Fletcher Allen Health Care Comprehensive Obstetrical and Gynecological Service (COGS) will work collaboratively with obstetric care providers to allow community-based care with transfer of care at 36 weeks for delivery at Fletcher Allen Health Care if needed. If these criteria cannot be met, strong consideration for all antenatal care and delivery at another institution should be considered.

Prenatal Care:

As long as the pregnancy has no complications and you are sure the patient is working closely with her substance abuse medication provider, global prenatal care is appropriate. Because of the high prevalence of smoking, careful assessment of dating and fetal growth is important.

At the initial visit, obtain HIPAA consent for communication that includes results of all lab tests including urine drugs screens. The communication consent should include the substance abuse treatment provider, counselor for compliance with visits and pediatrician. Discuss smoking reduction or cessation. Include HIV testing and Hepatitis C antibody screen to the standard prenatal lab tests that are ordered. The initial visit should confirm dating with ultrasound and should include a referral to community-based nursing program (Healthy Babies) .

Each visit:

- Confirm patient has seen methadone/buprenorphine provider (at least monthly)
- Document buprenorphine or methadone dose (patient report)
- Confirm that patient is receiving counseling (at least weekly)
- Encourage smoking reduction
- Confirm that community-based nursing has been established

15-20 weeks:

- Ultrasound for anomalies (especially if cocaine use in pregnancy)
- Refer to pediatric provider to discuss care of the neonate

28-34 weeks:

- Ultrasound for growth 32-34 weeks
- Discuss breastfeeding: Insufficient data regarding safety, may be reasonable with close pediatric follow-up
- If cesarean delivery planned: Refer to anesthesia for plan of pain control following surgery
- If your hospital has a pre-admission process, this is a good time to remind the staff a patient receiving opioid treatment will be delivering soon
- Meet with hospital based social work, if appropriate

Labor, Delivery and Postpartum:

During labor and delivery, as well as the postpartum process, reassure the patient that providing her adequate pain control is important. Conversations with obstetric and anesthesia providers should reflect that in a stable patient, there is no reason to suspect drug seeking if requesting pain medication in the appropriate clinical setting. Pediatrics should be notified that an opioid exposed neonate will be delivered soon.

A referral can be made to hospital based social work to evaluate any needs of the patient postpartum. During labor and delivery, continue scheduled methadone or buprenorphine during hospitalization. The obstetric provider can order these medications in the hospital even if not a buprenorphine prescriber, but will not be able to prescribe this medication after hospital discharge. An anesthesia consult should be made when the patient arrives in labor as indicated.

Neuraxial analgesia (spinal, epidural) is effective for pain control during labor or for cesarean delivery in opioid dependent women.

Intravenous short-acting **NALBUPHINE and BUTORPHANOL are CONTRAINDICATED** as they may precipitate withdrawal. If inadvertent administration occurs and the patient has withdrawal symptoms, an opioid-agonist should be administered to alleviate withdrawal symptoms; monitor for respiratory depression.

After the delivery, continue medication-assisted therapy as indicated and have hospital based social work see the patient.

For pain control, acetaminophen and non-steriodal anti-inflammatory agents should be used for mild and moderate pain with short-acting opioid analgesics used as needed. In a vaginal birth, short-acting opioids can be made available on a PRN basis, just as for non-opioid dependent patients.

Opioids for pain control should not be needed following discharge for a routine delivery. In the case of a cesarean delivery, continuous short-acting analgesics for 48 hours, patient controlled analgesia with intravenous morphine, or hydromorphone can be used the first 24 hours. Oral opioids can also be used.

You may expect a 70% increase in short-acting opioid analgesic requirement; often a more potent oral agent (hydromorphone) is required. Patient controlled epidural analgesia is effective for severe pain if available. Expect that short-acting opioids will be needed in decreasing amounts for 5-7 days following cesarean delivery.

BREASTFEEDING

Breastfeeding is encouraged for all patients (except those with HIV).

If breastfeeding is declined, switch the patient back to combination buprenorphine/naloxone immediately after delivery or continue methadone.

If breastfeeding is accepted, consult with pediatric provider to confirm that they are aware of patient's medication-assisted treatment use.

If newborn *is not* receiving methadone or morphine for neonatal abstinence syndrome, switch mother back to buprenorphine/naloxone. If the newborn *is* being treated with methadone or morphine for neonatal abstinence syndrome, continue buprenorphine monotherapy until neonate is off medication or weaned from breastmilk. There may be some patients in whom combination buprenorphine/naloxone is recommended; given evidence of minimal bioavailability in breastmilk, breastfeeding should be encouraged.

Postpartum Plan for Opioid-Agonist Medication:

There is currently no evidence that dose changes of methadone or buprenorphine are needed postpartum. Special attention for somnolence is warranted. Pay special attention to relapse, especially 3-6 months postpartum. There is anecdotal evidence to suggest that this is a particularly vulnerable time for a woman in recovery. Encourage continuation of community nursing for parenting support (or start initial referral at discharge if not done previously).

Ensure each patient has a follow-up appointment with BOTH her medication provider and substance abuse counselor.

CONTRACEPTION AND FERTILITY

As with many underlying diseases, as the patient's recovery proceeds, her fertility may also increase. Patients should not assume that because they have had infertility problems in the past that it will continue after treatment is initiated. If a patient is planning a pregnancy (or sexually active without contraception) , prenatal vitamins (800 mcg folic acid) are recommended prior to conception to reduce birth defects. If a patient is sexually active and not using contraception, prenatal vitamins should be recommended given high-risk of pregnancy.

Contraceptive counseling and treatment are available at low cost (or free) from community health clinics and Planned Parenthood. There is no evidence of medication interaction between oral contraceptives and methadone or buprenorphine. To afford the patient the best chance for a successful recovery, address her partner/family substance abuse treatment and plan, as indicated.

Common Clinical Challenges:

Women with a history of substance abuse often have chaotic lives, experience domestic violence, and have tenuous housing. The structure imposed by treatment programs can be a difficult adjustment. Relapses are common, especially early in treatment. A combined treatment plan developed by the patient with the obstetrician and medication provider that appropriately balances maternal and fetal risk is imperative.

Treatment Non-Adherence

The inability to remain abstinent, non adherence with counseling, or demonstration of other high-risk behavior constitutes treatment non-adherence.

Options include:

- Evaluate for more intensive services to more structured program (intensive outpatient program, residential treatment, methadone) using ASAM criteria.
- Discharge the patient from office-based therapy if she declines other options. Communication with the obstetrician, pediatrician, social work team at the hospital of planned delivery and the Department of Children and Families (DCF) should occur promptly.
- Useful cross discipline strategies for treatment non-adherence include linking the ability to pick up a buprenorphine prescription or methadone dose with prenatal care by requiring a visit to the obstetric provider office first. Consider linking the ability to pick up a buprenorphine prescription or methadone dose to counseling and referral to residential treatment or consider switch to methadone if adherence to office-based care is not possible.
- For recurrent positive drug screens with benzodiazepines, particular care must be taken in management of patients dependent upon benzodiazepines and opioids, due to synergistic respiratory depression,even if the benzodiazepines are prescribed. Provision for coordination of care must be made and consideration given to admission for benzodiazepine detoxification.
- Education should be given about the potential synergy between methadone, buprenorphine and benzodiazepines which includes warnings about driving or machine operation. This intervention should be documented in the medical record.
- Other strategies include an increase in counseling and consideration of alternative medication for anxiety (i.e.: sertraline). ***Patient may not be a candidate for office-based therapy if using benzodiazepines and might be better served at an opioid treatment center or residential treatment center.***
- For recurrent positive drug screens with cocaine, discuss the specific dangers of cocaine use in pregnancy including fetal loss, bleeding, preterm labor and fetal stroke. The patient may not be a candidate for office-based therapy if using cocaine and should be referred to an opioid treatment center or residential treatment for a more structured program. Education should be provided and documented regarding potential Levamasole contamination of cocaine.
- For recurrent positive drug screens with cannabis, use of any illicit substance should be discouraged. Given the relatively little data that THC is harmful in pregnancy combined with the clear benefit of opioid maintenance therapy, consider continuation with close follow-up or residential treatment.
- Non-adherence due to transportation and other social barriers present complex problems to successful recovery. Referral to community-based nursing/social work to develop a transportation plan (i.e.; Medicaid-sponsored transportation) should be made.
- Offer residential treatment for intensive counseling which can allow for less frequent (once a week) counseling after discharge. Inadequate housing, partner use of illicit substances, and domestic violence are common issues to be addressed with counseling and community-based nursing.

Clinical Risk Management Strategies:

Documentation is crucial and the following elements must be covered: referral for treatment, treatment refusal and planned use of medications not approved by the FDA, including use of methadone vs. buprenorphine. Document when Department of Children and Families notification of drug use is made. Ancillary services provided should be documented.

Clinical Management FAQs

The following scenarios may help obstetricians and medication providers understand treatment decisions. Close communication between providers will enable the optimal medical approach (as for any other medical illness):

Do I have to offer buprenorphine to a pregnant patient because she refuses methadone?

- ☐ The patient should receive the optimal care during pregnancy
- ☐ If she is not a candidate for buprenorphine, then she should receive methadone or referral to residential treatment
- ☐ Consider offering residential treatment and transfer to buprenorphine after successful completion of the residential program

Do I have to start buprenorphine immediately because the patient is pregnant?

- ☐ *Pregnancy is not an emergency*; simply a priority
- ☐ Confirm opioid dependence
- ☐ Confirm viable pregnancy

May I stop prescribing buprenorphine to the non-compliant patient during pregnancy?

- ☐ It is unsafe for the mother and fetus to continue to engage in risky behavior
- ☐ Medication can be discontinued for any medical reason when there is lack of benefit; alternatives should be offered (residential treatment; methadone treatment center)
- ☐ Continued high-risk behaviors in the office-based setting suggest the need for residential or center-based care.
- ☐ Document non-compliance and offers of alternative, more structured care

How do I know when to decline further office-based care with buprenorphine?

- ☐ Concurrent use of benzodiazepines
- ☐ Concurrent use of cocaine
- ☐ Difficulty engaging in counseling
- ☐ Can depend on ease of switching to methadone: assessment of overall maternal/fetal risk/benefit of continued treatment if no treatment is the option; the medication provider has some latitude if it is decided that risk/benefit favors office-based care

What should I do when I decide I cannot prescribe to a patient during pregnancy?

- ☐ Document rationale in medical record
- ☐ Offer methadone even if the patient needs to travel
- ☐ If option is buprenorphine versus no treatment:
  - Consider residential treatment
  - Consider supervised pregnancy residence
- ☐ Contact local child protection services when you discontinue medication; they can often follow-up in the hospital at delivery
- ☐ Tell the patient you must do this and document the conversation

Suggested "scripted" approaches to discussing treatment options

Initial visit script:

- Good for you in seeking help with addiction
- We need to confirm that you are pregnant and clarify the level and nature of your opioid abuse
- We routinely check the Vermont Prescription Monitoring System in all patients seeking treatment at our clinic
- Methadone is the medication of choice for the treatment of opioid dependence during pregnancy because we have years of experience with neonatal exposure
- I understand you would like to be treated with buprenorphine
- Buprenorphine is not approved for use in pregnancy and we do not have many years of experience; the oldest children are only 5 or 6
- Substance abuse counseling and engagement in community-based services to help with parenting is necessary for recovery and parenting
- Will you agree to attend counseling and receive help from community-based nursing?

Follow up sessions:

- I see that your have continued to use cocaine based on your toxicology screen. How shall we address this together?
- Let us review our plan for management of your pregnancy using buprenorphine/methadone
- Have you been able to keep your appointments with counseling and other medical providers?

Legal Issues Unique to Pregnancy FAQ

Misperceptions about legal issues are an important reason that opioid-dependent and pregnant women avoid treatment. Common misconceptions regarding treatment of the pregnant patient are addressed below.

Example: A 19 year-old with heroin addiction learns she is pregnant at a community health clinic.

Misconception: She should stop heroin immediately or she will go to jail
Fact: The American College of Obstetrics and Gynecology has a series of Committee Opinions that address ethical issues in Obstetrics and Gynecology, with the use of alcohol and illicit substances specifically considered.

- Pregnant women should be allowed to make decisions on their own behalf
- Most women will choose to proceed with treatment for the health of the fetus/newborn
- Incarceration, where there are few services, results in worse outcomes (mother: less prenatal care, less treatment, higher relapse; newborn: worse outcomes in foster care than with a recovering mother)

Misconception: She should not use opioid-agonist therapy because her baby will be an addict
Fact: Randomized trials have demonstrated the long-term (3 year) benefit of methadone treatment versus taper. Studies show less relapse and neonatal outcomes similar to controls (after demographic adjustment).

Misconception: She must receive opioid-agonist therapy although she requests a taper
Fact:

- Opioid-agonist therapy is clearly the treatment of choice as it improves prenatal care, reduces relapse, and reduces exposure to other illicit drugs.
- There are no data to suggest medication-assisted withdrawal early in pregnancy (before 24 weeks) is harmful
- Abrupt withdrawal from heroin late in gestation is associated with *in utero* withdrawal, increased meconium aspiration, and may be associated with fetal death
- Once informed, if the patient would like to taper, a gradual taper of 10% per week is reasonable. Many patients will become uncomfortable and stop a taper even after requesting it.

Misconception: If she has any relapses, she will lose custody of her child
Fact: Reporting laws vary by state, but most have some mandatory reporting of any maternal behavior that can impair the wellbeing of a child. However:

- Most states will work closely with a patient in recovery to allow her to maintain custody
- Many cannot intervene until after delivery (Vermont: case can be opened 30 days prior to expected delivery)
- Reinforce to the patient that treatment during pregnancy, even if has a few slips, will improve the chances of custody retention
- Reporting during pregnancy allows social work time to understand all aspects of patient care
- Reinforce to patient that the goal of all is to help her maintain custody and receive appropriate treatment for her to parent her child. The opioid-agonist treatment provider can play an important patient advocacy role here.

Appendix 1: HIPAA Form

MRN

PATIENT NAME

PATIENT DATE OF BIRTH

NOTICE OF PRIVACY PRACTICES

I have received the Notice of Privacy Practices at Fletcher Allen Health Care informing me of how Fletcher Allen Health Care will use my personal health information.

My understanding of this Notice will help me ensure the accuracy of my health information, better understand who, what, where and why others may access my health information.

I acknowledge receipt of the Notice and understand any questions pertaining to Fletcher Allen Health Care's privacy policies may be answered by contacting the Fletcher Allen Health Care Patient Relations Department at (802) 847-3500.

PATIENT / GUARDIAN

DATE OF RECEIPT

RELATIONSHIP TO GUARDIAN

☐ Patient unable to sign ☐ Patient refused to sign

Reason: _____

WITNESS

Appendix 2: Opioid-agonist Therapy During Pregnancy – OB Provider Checklist

PATIENT NAME _____ DATE OF BIRTH _____

MRN _____ DATE _____

☐ **Medication**

Medication Provider: _____

Dose: _____

☐ **Referrals**

Substance Abuse Counselor: _____

Maternal Child Health or Home Visiting Nurse: _____

☐ **0-20 Weeks**

- ☐ Additional labs: Hepatitis C antibody; HIV; liver panel
- ☐ Dating ultrasound
- ☐ Drug screen every visit
  - ☐ Check here if being done by the medication provider

☐ **24-32 Weeks**

- ☐ Refer to pediatrician: prepare for NAS scoring
- ☐ Refer for delivery elsewhere if needed

  Hospital of delivery: _____
- ☐ Develop a delivery plan

  Pediatrician: _____

  Anesthesia consult: _____

Appendix 3: Opioid Use During Pregnancy – Women Not in Treatment

PATIENT NAME _____ DATE OF BIRTH _____

MRN _____ DATE _____

☐ **Current substances used**

Frequency: _____

Dose: _____

Route: _____

If patient has symptoms of withdrawal when not using (sniffling, yawning, nausea, goosebumps, diarrhea, restlessness) then refer to a provider of opioid-agonist medication

☐ **Referrals**
See the list of Services for Opioid-Dependent Pregnant Women in Vermont

☐ Medication Provider/given a list of what is available in the community.

If there is no provider in your community, refer to closest available referral center. Fletcher Allen COGS clinic will accept and arrange treatment for any patient in their program.

☐ Substance Abuse Counselor

☐ WIC (MCH Coordinator)

☐ CIS Intake Coordinator

☐ Declines treatment
Call Social work at the hospital
Refer to DCF within 30 days of delivery
Watch fetal growth

Appendix 4: COGS Clinic Fax Transfer Form

Patient name: _____

Referring provider (with contact and fax number): _____

Reason for referral: _____

LMP (or gest age): _____ US done: ☐ YES ☐ NO (attach record)

Prior prenatal care: ☐ YES ☐ NO Provider: _____

Medications (dose and prescribing physician; note if you will continue prescribing medication or request transfer of prescribing responsibility and last day of medication): _____

_____

_____

Substance abuse counselor after discharge (note if we need to set this up): _____

Appointment: _____

Date and time: _____

Place: _____

Provider: _____

Social worker appointment: _____

Fax to COGS clinic:	802-847-8433
Phone:	802-847-1400
Email:	(provider to provider only): marjorie.meyer@uvm.edu
Note:	please do not use patient identifiable information in the email

Appendix 5: Community-Based Nursing/Social Services Checklist

PATIENT NAME _____ DATE OF BIRTH _____

MRN _____ DATE _____

☐ OB Provider: _____

☐ Medication Provider: _____

☐ Substance Abuse Provider: _____

☐ Primary Care Provider: _____

☐ Pediatrician: _____

☐ WIC

☐ Social Services

- ☐ Economic services
- ☐ Housing
- ☐ Employment
- ☐ Child care

Appendix 6: Communication Tool Fax Form

To:		From:	
Fax:		Pages:	
Phone:		Date:	

Name: _____

Date of birth: _____

Due date: _____

Medication/dose: _____

Visit type:

- ☐ Counseling
- ☐ OB visit
- ☐ Community nurse
- ☐ Pediatric visit

Date of visit: _____