

**Rules of**  
**Department of Health and**  
**Senior Services**  
**Division 40—Division of Maternal, Child and**  
**Family Health**  
**Chapter 6—Perinatal Substance Abuse**

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**Title 19—DEPARTMENT OF  
HEALTH AND SENIOR SERVICES  
Division 40—Division of Maternal, Child  
and Family Health  
Chapter 6—Perinatal Substance Abuse**

**19 CSR 40-6.010 Perinatal Substance  
Abuse Forms for Health Care Providers**

*PURPOSE: This rule establishes the forms and protocol to be used by health care providers to implement the perinatal substance abuse legislation in sections 191.725, 191.741 and 191.743, RSMo.*

(1) All licensed health care providers who provide obstetrical and gynecological care to pregnant women shall use the Department of Health form MCFH-4, the protocol required by section 191.741, RSMo, in Appendix A of this rule or any other assessment form which documents the substance abuse risk status of each patient. The medical record shall show documentation of this assessment.

(2) The health care providers designated in section (1) of this rule shall have all patients sign the Department of Health form MCFH-3 in Appendix B of this rule, or any form which is signed and dated by the patient and which states the substances discussed.

(3) To document the offer of service coordination for each pregnant woman at high risk for substance abuse, the health care providers designated in section (1) of this rule shall use the Department of Health form MCFH-2 in Appendix C of this rule and retain it in the medical record, or have documentation of the offer for service coordination and the woman's response in the medical record. The health care provider shall make the referral for service coordination to the Department of Health by telephone or in writing.

*AUTHORITY: sections 191.725, 191.741 and 191.743, RSMo Supp. 1991.\* Original rule filed Feb. 2, 1994, effective July 30, 1994.*

*\*Original authority: 191.725, RSMo 1991; 191.741, RSMo 1991 and 191.743, RSMo 1991.*



MISSOURI DEPARTMENT OF HEALTH  
DIVISION OF MATERNAL, CHILD AND FAMILY HEALTH  
**RISK ASSESSMENT FOR SUBSTANCE USE**

TOBACCO	OTHER DRUGS
<p>1. Have you ever smoked cigarettes? 1. <input type="checkbox"/> YES 2. <input type="checkbox"/> NO (Go to question 5)</p> <p>2. How old were you when you started smoking? _____ years</p> <p>3. In the month before finding out you were pregnant, on the average, how many cigarettes per day did you smoke? _____ number of cigarettes a day (24 hrs.)</p> <p>4. In the last week how many cigarettes, per day have you smoked. (average) _____ number of cigarettes a day (24 hrs.)</p>	<p>11. <b>Marijuana</b> <span style="float: right;">YES NO</span> 1) Have you ever used <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span> <span style="float: right;">If no, go to next drug</span> 2) Used in the past 12 months <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span> 3) Used since you became pregnant <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span></p> <p><b>Cocaine?</b> 1) Have you ever used <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span> <span style="float: right;">If no, go to next drug</span> 2) Used in the past 12 months <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span> 3) Used since you became pregnant <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span></p> <p><b>Amphetamines?</b> 1) Have you ever used <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span> <span style="float: right;">If no, go to next drug</span> 2) Used in the past 12 months <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span> 3) Used since you became pregnant <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span></p> <p><b>Hallucinogens?</b> 1) Have you ever used <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span> <span style="float: right;">If no, go to next drug</span> 2) Used in the past 12 months <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span> 3) Used since you became pregnant <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span></p> <p><b>Sedatives?</b> 1) Have you ever used <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span> <span style="float: right;">If no, go to next drug</span> 2) Used in the past 12 months <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span> 3) Used since you became pregnant <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span></p> <p><b>Narcotics?</b> 1) Have you ever used <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span> <span style="float: right;">If no, go to next drug</span> 2) Used in the past 12 months <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span> 3) Used since you became pregnant <span style="float: right;">1. <input type="checkbox"/> 2. <input type="checkbox"/></span></p> <p><b>If no drug use ever - END</b></p> <p>12. Have you ever felt you should cut down on your drugs? 1. <input type="checkbox"/> YES 2. <input type="checkbox"/> NO</p> <p>13. Have people annoyed you by criticizing your using drugs? 1. <input type="checkbox"/> YES 2. <input type="checkbox"/> NO</p> <p>14. Have you felt badly or guilty about your using drugs? 1. <input type="checkbox"/> YES 2. <input type="checkbox"/> NO</p> <p>15. Have you ever used drugs first thing in the morning to steady your nerves or get rid of a hangover? 1. <input type="checkbox"/> YES 2. <input type="checkbox"/> NO</p>
<p><b>ALCOHOL</b></p> <p>5. In the month before finding out you were pregnant, how many drinks of alcohol did you typically have per week? 1. <input type="checkbox"/> None 2. _____ number of drinks per week (1 drink - liquor = 1 oz. 1 beer = 12 oz. 1 glass of wine = 5 oz.)</p> <p>6. In the last week, how many drinks of alcohol have you had? 1. <input type="checkbox"/> None (Go to question 11) 2. _____ number of drinks per week</p> <p>7. Have you ever felt you should cut down on your drinking? 1. <input type="checkbox"/> YES 2. <input type="checkbox"/> NO</p> <p>8. Have people annoyed you by criticizing your drinking? 1. <input type="checkbox"/> YES 2. <input type="checkbox"/> NO</p> <p>9. Have you felt badly or guilty about your drinking? 1. <input type="checkbox"/> YES 2. <input type="checkbox"/> NO</p> <p>10. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? 1. <input type="checkbox"/> YES 2. <input type="checkbox"/> NO</p>	
CLIENT NAME	PROVIDER NAME <span style="float: right;">DATE</span>

**INSTRUCTIONS FOR USE**

There is no standard method of inquiring about alcohol or drug abuse, during the initial work-up. Many health care providers find it most comfortable and natural to introduce this line of questioning after inquiring about matters of general health and dietary habits. In this way, it is easy to progress from over-the-counter and prescribed medications to tobacco, alcohol and finally, the illicit substances. Alternatively, the subject can be introduced during the family history; by inquiring about the substance use/abuse of immediate family members and progressing to the habits of the individual. The assessment is designed to move quickly but efficiently; by highlighting any “red flags” which identify women at risk for substance use and who therefore, require further evaluation.

Although, this form is not a required component of the permanent medical record, it may be retained in the client’s chart to document the assessment and it’s results, as well as the date, location and name of the provider.

**CRITERIA FOR REFERRAL**

A definite referral should be offered to all women who:

- 1) respond affirmatively to two or more of questions 7 through 10 or questions 12 through 15, **OR**
- 2) respond affirmatively to recent use or continued use despite awareness of their pregnancy status.

If referral is refused, she should be reassessed at **each** subsequent visit and again, offered referral based on her status.

Periodic reassessment should be offered to those women who:

- 1) have a history of prior heavy use of alcohol or other drugs, but deny current use or use since their pregnancy status was known to them, **OR**
- 2) Have significant psycho-social risk factors; such as a positive family history for substance abuse, physical or sexual abuse, lack of academic success, lack of peer or social support systems, lack of economic independence, friends who use drugs, co-dependency, depression, history of prostitution or multiple STD’s etc.

Regular monitoring may provide the pregnancy client with sufficient motivation to persevere in their attempts to discontinue use, if the benefits of abstinence are stressed and any positive results are reinforced.

**ALTERNATIVE TERMINOLOGY FOR ILLICIT SUBSTANCES**

For those drugs listed under question number 11, it may be more appropriate to utilize the “street names” or slang terminology which is most prevalent in your area. For your convenience, several alternatives are suggested below:

- 1) Marijuana - grass, weed, joint, reefer, kif, herd, hashish, hash oil.
- 2) Cocaine - coke, crack, base, blow, toot, rock, snow, uptown.
- 3) Amphetamines - meth, crank, uppers, speed, crystal, ice, dex, black beauties, bennies, copilots, beans.
- 4) Hallucinogens - LDS, acid, love drug, cactus, buttons, peyote, magic mushrooms.
- 5) Sedatives (tranq., diazepines, barb.) - blues, downers, yellow jackets, rainbows, ludes, reds.
- 6) Narcotics (codeine, demerol, percodan, heroin, methadone) - schoolboy, smack, junk, downtown.
- 7) PCP - angel dust, zombie, supercools, green.
- 8) Inhalants (amyl nitrite, toluene) - huffing tuleo, glue, kick, poppers, snappers, rush.



MISSOURI DEPARTMENT OF HEALTH  
DIVISION OF MATERNAL, CHILD AND FAMILY HEALTH  
**ACKNOWLEDGEMENT OF COUNSELING**

**My health care provider has discussed with me the effects of:**

- ALCOHOL (BEER, WINE, WINE COOLERS, LIQUOR)
- TOBACCO (INCLUDING SECOND HAND SMOKE)
- PRESCRIPTION DRUGS (WITHOUT DOCTOR ADVICE)
- OVER THE COUNTER MEDICATION (WITHOUT DOCTOR OR PHARMACIST ADVICE)
- OTHER DRUGS (STREET) SUCH AS: CRACK/COCAINE, MARIJUANA, BARBITURATES, AMPHETAMINES, ETC.

**on my own health and the health of my unborn child.**

**LITERATURE GIVEN:**

- DOH PAMPHLET       TOBACCO       OTHER DRUGS
- ALCOHOL       COCAINE

I understand this information, and have been given the opportunity to ask questions concerning substance abuse in pregnancy.

I have been given a toll-free number to call if I should need information or assistance with the problem of substance abuse during my pregnancy.

CLIENT SIGNATURE	DATE
PROVIDER SIGNATURE	DATE



MISSOURI DEPARTMENT OF HEALTH  
 DIVISION OF MATERNAL, CHILD AND FAMILY HEALTH  
**INFORMED CONSENT FOR SERVICE COORDINATION REFERRAL**

I hereby give permission to have my name provided to the Missouri Department of Health for the purpose of receiving additional services which may be helpful to me and my family and which will be coordinated by the Department of Health. I understand my physician/health care provider believes these services are important for my health and the health of my baby. My doctor/nurse practitioner/clinic will continue to provide medical care for me during my pregnancy.

I understand the Department of Health will not share any information about me without my consent, nor can any such information be used for criminal prosecution.

I understand that I may refuse these services at any time.

I have read the above material, and have been given an opportunity to ask any questions I may have regarding the service coordination referral process.

CLIENT SIGNATURE ▶		DATE
WITNESS SIGNATURE ▶		DATE
DATE REFERRAL MADE	PERSON CONTACTED	DATE CCI SENT TO DOH

I have read the above material, and have been given an opportunity to ask any questions I may have regarding the service coordination referral process.

I am not interested in a referral to the Department of Health at this time.

CLIENT SIGNATURE ▶		DATE
WITNESS SIGNATURE ▶		DATE

**MAY USE REVERSE SIDE TO DOCUMENT OFFER OF REFERRAL AND CLIENT RESPONSE**

