Connecticut Department of Children and Families
MEDICAL QUESTIONNAIRE
DCF-748 HRNB
9/19 (Rev.)

Date:	Infant's Name:	Infant's DOB:
Infant's Legal Status: Please Select One	DCF SW Name:	DCF SWS Name:
Release of Information ☐ On File ☐ On File at DCF ☐ Attached	Name of Hosptial Staff Completing this form:	

The Department of Children and Families has an open case concerning the child listed above. In accordance with our policies, we are requesting information that would become part of the case file. Enclosed or available is a signed authorization to release information for your records. We ask that you take a moment to complete this form and return it to us. Thank you for your anticipated assistance in this matter.

COMPLETE FOR INITIAL MEDIAL INFORMATION REQUEST

Hospital:	
Maternal Age:	Previous Pregnancy and Delivery History:
Supports:	
Did mother receive any prenatal care?: ☐ Yes ☐ No	Was she compliant with care?: ☐ Yes ☐ No
PRENATAL: Maternal infections/serologies/lab work: (VDRL, Rubella, Hepatitis B, Hepatitis C, Group B strep, HIV, other)	
Medical complications of pregnancy:	
Prescribed medications used during pregnancy:	
Drugs: (Include: name of drug(s), amount/length of use, and reported last date and time of use)	
Documented toxicology screens: (where/when/how often)	
Gestational Age:	DELIVERY: (Any complications?):

Any medication/treatment received during labor/delivery:	Mother:	Infant:

APGARS:	Resuscitation needed?	Type?	Birth weight: (SGA, AGA, LGA)	Length:	Head circumference:

COMPLETE FOR INITIAL AND FOLLOW-UP MEDIAL INFORMATION REQUEST

INFANT Current Weight:	Feeding: ☐ Formula ☐ Breast	Route: ☐ PO ☐ NG TUBE ☐ OG TUBE ☐ IV

Calories/ounce:	Amount per feeding:	How often:	Tolerating: (spitting/vomiting)

Elimination:	Sleep patterns:
Complications and plan/treatment: (i.e. from prematurity, is the baby receiving supports? for example, oxygen/temperature/lights)	

COMPLETE FOR INITIAL AND FOLLOW-UP MEDIAL INFORMATION REQUEST (Continued)

Neonatal Abstinence Scores/symptoms/plan:

Medication: (dose/schedule/route)

Urine toxicology and/or meconium results: (if not resulted, date sent)

Circumcision completed: (if applicable) ☐ Yes ☐ No	Received Hep B: (date)	
Hearing screen: ☐ Pass ☐ Fail	Cardiac screen: ☐ Pass ☐ Fail	Car seat screen: ☐ Pass ☐ Fail

Parent contact/engagement/strengths: (who has been present to visit the baby? Are there any concerns with visitors?)

MD/Nursing concerns:

Projected discharge date and plan:

Safe sleep discussed with caregiver prior to discharge: ☐ Yes ☐ No

FOLLOW-UP NEEDED

Who	When:
1. Pediatrician:	
2. Specialist:	
3. B23 referral	
4. VNA	
5. Others	

☐ Need to Speak with RRG Nurse	Best Days and Times to Contact:		
	Day(s);	Time(s):	Phone:

Name of Person Completing Form	Signature of Person Completing Form:	E-mail	Date:

REGIONAL NURSE MAILBOXES

Region 1 (Bridgeport/Norwalk):	RRGNURSESREGION1@ct.gov	Region 2 (New Haven/Milford):	RRG.NURSESREGION2@ct.gov
Region 3 (Norwich/Middletown/Willimantic):	RRG.NURSESREGION3@ct.gov	Region 4 (Hartford/Manchester):	RRG.NURSESREGION4@ct.gov
Region 5 (Waterbury/Danbury/Torrington):	REGION5RRG.NURSINGMAILBOX@ct.gov	Region 6 (New Britain/Meriden):	RRG.NURSESREGION6@ct.gov