**Directions:** Please complete all of the information below. Once the referral is received, the program coordinator will reach out to the parent/guardian within 3 business days to schedule a Safe Sleep class, and receive a Survival Kit if they meet the criteria for the program.

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Baby’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday/Due Date: \_\_\_\_\_\_\_\_\_\_\_ Gender M F

Race: Asian Black White Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity: Hispanic Non-Hispanic

Does the family own a crib or bassinet at this time? Yes, parent owns a \_\_\_\_\_\_\_\_\_\_\_\_\_ No

Where does the baby currently sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Sleep Position: Belly Back Side

Environmental Smoke: Mother smoked during pregnancy

 Mother will smoke after pregnancy

 Identify Location Inside Outside

 Members of household smoke

 Identify Location Inside Outside

Health Insurance: Mother Yes No Baby Yes No

Childcare: Home-based Center-based Relatives/Friends None

*Please Mail or Email forms to:*

**Cortney Ardrey, Program Coordinator**

**428 West Liberty St.**

**Wooster, Ohio 44691**

**Office: (330)-264-2426**

**cardrey@wayne-health.org**