Cribs for Kids© Referral Form

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:

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