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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