Cribs for Kids® Program Referral Form

****Please FAX this form to (315) 424-0190****
or email to cribsforkids@reachcny.org

Parent's/Guardian's Name: ________________________________ **Mother's DOB**_______________

Address: ____
Street City State ZIP

Home Phone Number: ____________________ **Cell Phone Number**: ___________________________

Mother's Race: Caucasian African American/Black Other _____________

Mother's Ethnicity: Hispanic Not Hispanic

Health Insurance: Medicaid Private Uninsured Ineligible Other___________________________

Primary Care Physician: Yes No

Infant DOB: ______________ or **Estimated Due Date**: _____________

Risk Factors

Current Sleep Location: Adult Bed Car Seat Sofa Unsafe crib Other___________________ N/A

Current Sleep Position: Tummy Back Side N/A

Mother smoked: during pregnancy after pregnancy does not smoke

Others smoke in household: No Yes

If yes, identify location: inside home outside in car/truck

Other significant sleep risk: _________________________

Referring Agency: ____________________________________ **Date of Referral:** __________________

Contact Person: ______________________________________ **Phone:** __________________________

Email: ____

Referral sent via: Fax Email

Parent/Caregiver Consent: I agree to allow REACH CNY Inc. or a partner agency staff to contact me to deliver safe sleep education, determine eligibility and demonstrate how to set up a portable crib. I understand that the information on this form will be kept confidential.

Parent/Guardian Signature__________________________________ Date________________