Cribs for Kids® Program Postpartum Referral Form

****Referral should only be made AFTER a home visit has been completed*****

Today's date: _____ Baby's date of birth: _____ **(must be <9 months of age)**

Please complete ALL sections of this referral form and fax to (516)227-9644. After this form is received, and the client is approved, we will contact you to schedule crib pick-up. The referring agency is responsible for completing the safe sleep education and related forms within 2 business days of crib pick-up.

Parent/Guardian Information:

Name of Mother/Guardian: _____

Maternal Birth Date: _____

Name of infant:_____

Relationship to this child: _____

and age of children in this household: _____

Address:_____City _____ State _____ Zip_____

Is this residence: □ permanent □ temporary

Home Phone Number: _____ Cell Phone Number: _____

Secondary Contact Information: Name_____ Relationship:_____

Phone Number:_____

Infant Information:

Was your baby born early? ____Yes _____No **If yes**, how many weeks early was the baby born? _____

Twin or multiple birth? ____Yes ____No

Comments:_____

Where does your baby currently sleep? _____

In what position does the baby sleep? □Tummy □Back □Side

Demographic Information:

Maternal Education Level: ____Some high school ____2-year community college graduate

____High school graduate ____4-year college graduate

____G.E.D. certificate ____Graduate school

____Other, please explain_____

Race: *(check all that apply)* ____ Asian ____ Black ____ White _____American Indian ____Asian/Pacific Islander ____Other

Ethnicity: ____ Hispanic ____ Non-Hispanic

Environmental Smoke:

A. Did Mother ever smoke during pregnancy: Yes/No (circle one)

B. Has Mother smoked after pregnancy: Yes/No (circle one)

Identify location ____ inside ____ outside

C. Do members of household smoke: Yes/No (circle one)

Identify location ____ inside ____ outside

Eligibility:

Are you working now? □ Yes □ No □Maternity leave

Is anyone else in your household working? □ Yes □ No

Is your family receiving any of the following benefits? *Check all that apply*

□ TANF

□ WIC

□ Food stamps/SNAP

□ Child Care Subsidy

□ Disability

□ SSI

□ Section 8 housing

□ Unemployment

Health Insurance: Mother ____ Yes ____No

Do you have a:

□Crib □Pack n' Play □Bassinet □Other_________

Child Weight: __________ (must be less than 30 pounds for portable crib)

Childs Height: _______ (must be less than 35 inches for portable)

Referral Source:

Referring Agency: ___________________________________ **Contact Person:** ______________________

Date of Referral: ___________ **Telephone Number:** _____________ **Email:** ________________________

Any other information you would like us to know:

____

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Agreement for Referral:

I agree to allow ___________________________________ to provide my referral information to the Nassau County Cribs for Kids® Program to obtain a crib for my baby. I understand that this does not guarantee that I am eligible to receive a crib. I understand that my information will be kept confidential and may be used to plan education and programs to reduce the risk of infant death. I understand that I will be contacted by the Cribs for Kids Program and its' partners in the future for follow-up. I understand that the safest place for my baby to sleep is on their back in a safety-approved crib. I am aware that this crib cannot be returned to the store for money.

Mother or Guardian of Baby ________________________ Date ______________________

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Does parent want the safe sleep literature that comes with the crib in English or Spanish?_____