



Cribs for Kids Program – Referral Form

Name of Mother/Guardian: _____ **Maternal Birthdate:** _____

Address: _____
City State Zip

Home Phone Number: _____ **Cell Phone Number:** _____

Race: ___ Asian ___ Black ___ White ___ Other

Ethnicity: ___ Hispanic ___ Non-Hispanic

Baby's Name: _____ **Date of Birth:** _____ **Baby's Due Date:** _____

Health Insurance: Mother ___ Yes ___ No Baby ___ Yes ___ No

Current Sleep Location: ___ Bed ___ Car Seat ___ Sofa _____ Other (specify)

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

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

Referring Agency: _____ **Contact Person:** _____

Date of Referral: _____ **Telephone Number:** _____ **Email:** _____

Agreement for Referral

I agree to allow _____ to provide my referral information to 'Cribs for Kids'® Program to obtain a crib for my baby. I understand that the safest place for my baby to sleep is on their back in a safety-approved crib.

Mother or Guardian of Baby Date