REACH CNY

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

Childcare: Home-based Center-based Relatives/Friends Not in Childcare

Infant Feeding: Breastmilk Only breastmilk & formula Formula Only Solids

Other significant sleep risk: _____

Referring Agency: _____ **Date of Referral:** _____

Contact Person and Email : _____

Phone: _____

Referral sent via: Fax Email

Parent/Caregiver Consent: I agree to allow REACH CNY Inc. or the referring agency to contact me 30 to 60 days after I receive the portable crib to conduct a brief follow-up survey. I understand that the information on this form will be kept confidential.

Parent/Guardian Signature_____ Date_____

Cribs for Kids®
Helping every baby sleep safer