sids
SUDDEN INFANT DEATH SERVICES
of illinois, inc.

Date: _____

Referred by: (please print clearly!)

Name: _____

Agency: _____

Agency Address, City, State, ZIP: _____

Agency Telephone #: _____ Pager/Cell #: _____

Email: _____ Website: _____

Family Information:
Does the family receive any public assistance? (circle all that apply)

SSI LINK WIC TANF Medicaid Benefits: Yes No

Patient Information:

Name of mother _____ Does mom smoke? Yes No

Age of mother (in years) _____

Language – Does mom speak English or have someone to translate? _____

Insurance Carrier for mother _____

Mother's Address: _____

City/State/ZIP:_____

Phone:_____ Allows Text Messaging? Yes No

Additional phone number: _____

Due date/baby's birthdate: _____

Baby's name: _____

Twins? _____

How many Cribettes need to be distributed to this family? _____

How many adults in household? _____ Does anyone smoke in the home? Yes No

Children: _____ Ages of children in household:

_____ _____

_____ _____

_____ _____

I authorize the referring agency to share the above information with SIDS of Illinois, Inc.

_____ (Client signature) Date _____

Mail completed forms to Nancy Maruyama, RN, BSN. NCBF via USPS or Fax to 630-541-8246

May email to nancy@sidsillinois.org if using **encryption.**