

Patient Access to Safe Sleep Environment Screening – Data Collection

ORC 3701.66 establishes an infant safe sleep screening procedure for hospitals. Hospitals are required to screen new parents and caregivers prior to the infant's discharge home to determine if the infant has a safe sleep environment at his/her residence. The data collection below is in reference to screenings from the preceding calendar year (select year from the drop down menu):

Contact Information:

Facility Name: _____

Name (person completing the form): _____

Phone: (____) _____ - _____ Email: _____

SECTION I (Provide the number for each selection below)

How many caregivers reported **YES** that they had a safe crib, bassinet or play yard with a firm mattress for their infant to sleep in after being discharged from the hospital? _____

How many caregivers reported **NO** that they did not have a safe crib, bassinet or play yard with a firm mattress for their infant to sleep in after being discharged from the hospital? _____

SECTION II (Complete Section II on those responding NO)

Referral to a Crib: (Provide the number for each selection below)

Facility provided infant a safe crib using its own resources. _____

Facility provided infant a safe crib by collaborating with or obtaining assistance from another person or government entity. _____

Facility referred parent/guardian/other person responsible for infant to person or government entity to obtain a safe crib. _____

Facility referred parent/guardian/other person responsible for infant to a site designated by ODH to obtain a safe crib. _____

(Continue on next page)

Email: safesleep@odh.ohio.gov



SECTION III (Complete Section III for those caregivers referred for a crib)

(Provide the number for each selection below. If more than one category was selected, count them in the multiple race category)

Race:

American Indian or Alaska Native _____

Asian _____

Black or African American _____

Native Hawaiian & Other Pacific Islander _____

White _____

Multiple Races _____

Unspecified _____

Ethnicity:

Hispanic _____ Non-Hispanic _____ Unspecified _____

Delivery Payment: Principal source of payment for this delivery.

Medicaid _____ Other _____

Home ZIP Codes: List each unique ZIP Code reported and how many referrals for each ZIP code.

ZIP Code	Total # of Referrals	ZIP Code	Total # of Referrals	ZIP Code	Total # of Referrals

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