KIDS
Kansas Infant Death and SIDS Network

Community Baby Shower for Safe Sleep

PRE TEST

Name of Mother: _____ **Mother's Date of Birth:** _____
First Last

Baby's Date of Birth or Due Date: _____ **Email Address:** _____

Cell Phone Number: _____ **Okay to text message?** ☐ Yes ☐ No

Mother's Race/Ethnicity: ☐ African American ☐ White ☐ Hispanic ☐ Multiracial ☐ Other

Marital/Partner Relationship Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced

Marital/Partner Race/Ethnicity: ☐ African American ☐ White ☐ Hispanic ☐ Multiracial ☐ Other

1. Mother's Education Level (years of school completed):

☐ Some high school ☐ 2-year community college graduate
☐ High school graduate/G.E.D. certificate ☐ 4-year college graduate
☐ Graduate school (completed degree) ☐ Other, please explain _____

2. Type of Insurance (for Mother of baby): ☐ Private Insurance ☐ Medicaid ☐ Managed Care Organization
☐ Military ☐ None ☐ Other (specify) _____

3. Where do/did you receive prenatal care: ☐ Private Provider's Office ☐ Clinic at work/school
☐ County Health Department ☐ Hospital Clinic ☐ Hospital Emergency Room/as needed care provider
☐ Community Health Center ☐ None ☐ Other (specify) _____

4. How will you lay your baby down to sleep? (check all that apply)

☐ On the back ☐ On the tummy ☐ On the side ☐ Not sure

5. Where will your baby sleep at home? (check all that apply)

☐ In a bassinet next to my bed ☐ In a crib in the baby's room ☐ Don't know/not sure
☐ In a portable crib next to my bed ☐ On a twin or larger mattress or bed ☐ Swing/car seat
☐ In a crib in my room ☐ In my bed ☐ Couch/sofa/armchair

6. Please check the items that are already in your baby's sleeping area at home, or that you plan to get for your baby's sleeping area.

☐ Firm Mattress ☐ Loose Blanket ☐ Cushions/pillows/nursing pillows ☐ Sleep Positioner
☐ Fitted Sheet ☐ Bumper Pad (mesh/non-mesh) ☐ Stuffed Toy ☐ Wearable blanket/sleep sack

7. Have you talked about Safe Sleep with others who may put your child down to sleep? ☐ Yes ☐ No

8. Have you used tobacco (including e-cigarettes) in the past 6 months? ☐ Yes ☐ No

9. How often do you currently use tobacco (including e-cigarettes)? ☐ Never ☐ Daily ☐ Weekly ☐ Monthly

10. Will you allow anyone to use tobacco (including e-cigarettes) inside your home or car?
☐ Never ☐ Daily ☐ Weekly ☐ Monthly

11. Do you know at least three ways to avoid second-hand smoke exposure for your baby? ☐ Yes ☐ No

12. How many local resources do you know about to quit tobacco use?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

13. Are you interested in quitting tobacco use? ☐ Yes, in the next 30 days ☐ Yes, but not now
☐ I'm not ready to quit ☐ I don't use tobacco

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14. How likely are you to breastfeed?

☐ not likely ☐ somewhat likely ☐ very likely

15. How long do you plan to breastfeed your baby?

☐ none ☐ 1-2 weeks ☐ up to 3 months ☐ up to 6 months ☐ up to 1 year ☐ over 1 year

16. I am confident I will breastfeed:

☐ Don't plan to breastfeed ☐ Up to 3 months ☐ Up to 6 months ☐ Up to 1 year ☐ Over 1 year

17. How many local resources do you know about to support your breastfeeding goals?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

	Please select whether the following are true or false:	**True**	**False**
18.	**My baby is at risk of dying of SIDS.**		
19.	**Loose blankets in the crib can cause infant death.**		
20.	**Sleeping with my baby can cause infant death.**		
21.	**Putting my baby alone, on the back in a crib will help protect her.**		
22.	**My baby will choke on his back.**		
23.	**I can't keep my baby warm without blankets.**		
24.	**I don't have room for a crib in my room.**		
25.	**People tell me different things about how my baby should sleep and I don't know what to do.**		