|  |  |
| --- | --- |
| Name: | Organization |
| Date: | Year |  |
| **# of interventions completed:** |  |  |  |
| **Please check what intervention** |
|  |  | Safe sleeping | Did you provide counseling? | Yes No |
|  |  |  | Did you provide a crib/box? | Yes No |
|  |  | Family smoking | Did you refer to smoking quit line? | Yes No |
|  |  | Poisoning risk | Did you provide counseling? | Yes No |
|  |  |  | Did you refer to 1800-222-1222? | Yes No |
|  |  | Car seat | Did you provide counseling? | Yes No |
|  |  |  | Did you provide a new car seat?  | Yes No |
|  |  | Smoke Detector/CO detector | Did you provide new detectors? | Yes No |
|  |  |  | Did you provide new batteries? | Yes No |
|  | Please add additional comments: |
|  | Please Let us know if you need additional training or assistance:  |