EOCCO Cribs for Kids®
Program – Referral Form

eocco
EASTERN OREGON
COORDINATED CARE
ORGANIZATION

Mother's name:	Mother's DOB:	Medicaid ID #:	
Address:	City	State	ZIP
Shipping address, if different than above:			
Home phone #:	Cell phone#:		

I would like my kit in: ☐ English ☐ Spanish

Member Agreement for Referral

I agree to allow _____ (clinic name) to provide the information on this form to the Cribs for Kids® Program and EOCCO. I understand that the safest place for my baby to sleep is on their back in a safety-approved crib.

_____ _____
Signature of mother or guardian of baby Date

Clinic Agreement

Clinic name:	Date of referral:	Telephone #:
Contact person name:	Contact person email address:	
Member's expected delivery date:	Verified member's eligibility: ☐ Yes ☐ No Check the box if mother is having twins ☐	

I, _____ (clinic name), provided safe sleep education during the member's visit.

_____ _____
Signature of referring provider Date

*Referring clinic: Please complete the required information on page 2.

Evidence of prenatal care or postpartum care:

To qualify for this program, the mother needs to have medical records that show they had prenatal or postpartum care. Please fill out the rest of this form to confirm that the mother had prenatal or postpartum care that was noted in her medical records.

If the visit(s) is with a family practitioner or PCP, there must be a pregnancy diagnosis at the time of service.

Evidence of one of the five services is required. Please check the box for all services the apply. Then, write the visit(s) date.

Prenatal checklist

1. A basic physical obstetrical exam that includes one of the following (check all that apply):

   ☐ Auscultation for fetal heart tone or Visit date: _____

   ☐ Pelvic exam with obstetric observations or Visit date: _____

   ☐ Measurement of fundus height Visit date: _____

2. Evidence that a prenatal care procedure was performed, such as (check all that apply):

   ☐ Complete obstetric panel or Visit date: _____

   ☐ TORCH antibody panel or Visit date: _____

   ☐ Rubella antibody test with ABO/Rh blood typing or Visit date: _____

   ☐ Echography of a pregnant uterus Visit date: _____

3. Documentation of LMP or EDD together with either of the following (check all that apply):

   ☐ Prenatal risk assessment and counseling/education or Visit date: _____

   ☐ Complete obstetrical history Visit date: _____

Postpartum checklist

1. A basic physical obstetrical examination that includes one of the following (check all that apply):

- ☐ Pelvic exam or — Visit date: _____
- ☐ Evaluation of weight, blood pressure, breasts and abdomen or — Visit date: _____
- ☐ Pap test — Visit date: _____

2. Notation of postpartum care, including, but not limited to the following (check all that apply):

- ☐ Notation of "postpartum care," "PP care," "PP check," or "6-week check" or — Visit date: _____
- ☐ A preprinted "Postpartum Care" form in which information was documented during the visit — Visit date: _____

Members should receive their safe sleep kits within two to three weeks from the date the form is submitted to EOCCO. Eligibility will be verified before processing the referral form. We cannot process incomplete forms. They will be sent back to the referring provider.

Questions?

Please contact eoccometrics@modahealth.com.

Email the completed form to eoccometrics@modahealth.com
or fax to 503-265-4790 Attn: Medicaid Services