The Safe Sleep assessment

* Please place a sticker (if available) othe

Health professional assessment (signatures)

Midwife: ....

(Interpreter): ....

Date: ..../........./.........

Health Visitor: ....

(Interpreter): ....

Date: ..../........./.........

Surname:

First names:

NHS number: Unit no:

Address: ....

.... Post code: ....

G.P: Code:

H.V: Code:

(Further information can be entered on notes pages at back of record if needed)		Yes/No (MW)	Yes/No (HV)	MW: Any concerns identified? Plan to reduce any risk
1	Where did the baby sleep last night? Is this where baby normally sleeps? Where does baby sleep in the day? - Advice for the first 6 months			
2	Is baby placed on back to sleep?			
3	Is baby placed feet to foot?			
4	Is temperature of room/ clothing of baby as advised?			
5	Is the cot free of pillows and soft toys?			
6	Do parent(s) or key carers ever sleep on a sofa or armchair with the baby?			
7	Do parent(s) or any key carers smoke?			
8	Do parent(s) or any key carers drink alcohol?			
9	Do parent(s) or any key carers take any drugs or medication?			
10	Have parent(s) /key carers considered safer sleep when away from home?			
11	Are parent(s) or key carers aware of signs that baby is unwell and know how to seek advice?			
12	**Health Professional:** Have you seen where the baby sleeps?			

Top copy remain in PCHR 2nd copy to Midwife 3rd copy to HV 4th copy to Child Health (if required)