

Reporting Form

INVESTIGATION DATA

Infant's Information: Last: _____ First: _____ M. _____ Case# _____

Sex: Male Female Date of Birth _____ / _____ / _____ Age _____ SS# _____
Month Day Year

Race: White Black/African Am. Asian/Pacific Islander Am. Indian/Alaskan Native Hispanic/Latino Other

Infant's Primary Residence Address:

Address _____ City _____ Zip _____

Incident Address:

Address _____ City _____ Zip _____

Contact Information for Witness:

Relationship to the deceased: Birth Mother Birth Father Grandmother Grandfather
 Adoptive or Foster Parent Physician Health Records Other:

Last _____ First _____ M. _____ SS# _____

Home Address _____ City _____ State _____ Zip _____

Place of Work _____ City _____ State _____ Zip _____

Phone (H) _____ Phone (W) _____ Date of Birth _____

WITNESS INTERVIEW

1 Are you the usual caregiver? Yes No

2 Tell me what happened:

3 Did you notice anything unusual or different about the infant in the last 24 hrs? No Yes ⇨ Describe: _____

4 Did the infant experience any falls or injury within the last 72 hrs? No Yes ⇨ Describe: _____

When was the infant **LAST PLACED**? _____ / _____ / _____ : _____
Month Day Year Military Time Location (room)

6 When was the infant **LAST KNOWN ALIVE (LKA)**? _____ / _____ / _____ : _____
Month Day Year Military Time Location (room)

7 When was the infant **FOUND**? _____ / _____ / _____ : _____
Month Day Year Military Time Location (room)

8 Explain how you knew the infant was still alive. _____

9 Where was the infant - (P)laced, (L)ast known alive, (F)ound (circle P, L, or F in front of appropriate response)?

- | | | | |
|---------------------------|--------------------------|----------------|--------------------------|
| P L F Bassinet | P L F Bedside co-sleeper | P L F Car seat | P L F Chair |
| P L F Cradle | P L F Crib | P L F Floor | P L F In a person's arms |
| P L F Mattress/box spring | P L F Mattress on floor | P L F Playpen | P L F Portable crib |
| P L F Sofa/couch | P L F Stroller/carriage | P L F Swing | P L F Waterbed |
| P L F Other _____ | | | |

WITNESS INTERVIEW (cont.)

- 10** In what position was the infant **LAST PLACED**? Sitting On back On side On stomach Unknown
 Was this the infant's usual position? Yes No ⇨ What was the infant's usual position? _____
- 11** In what position was the infant **LKA**? Sitting On back On side On stomach Unknown
 Was this the infant's usual position? Yes No ⇨ What was the infant's usual position? _____
- 12** In what position was the infant **Found**? Sitting On back On side On stomach Unknown
 Was this the infant's usual position? Yes No ⇨ What was the infant's usual position? _____
- 13** **FACE** position when **LAST PLACED**? Face down on surface Face up Face right Face left
- 14** **NECK** position when **LAST PLACED**? Hyperextended (head back) Flexed (chin to chest) Neutral Turned
- 15** **FACE** position when **LKA**? Face down on surface Face up Face right Face left
- 16** **NECK** position when **LKA**? Hyperextended (head back) Flexed (chin to chest) Neutral Turned
- 17** **FACE** position when **FOUND**? Face down on surface Face up Face right Face left
- 18** **NECK** position when **FOUND**? Hyperextended (head back) Flexed (chin to chest) Neutral Turned
- 19** What was the infant wearing? (ex. t-shirt, disposable diaper) _____
- 20** Was the infant tightly wrapped or swaddled? No Yes ⇨ Describe: _____

21 Please indicate the types and numbers of layers of bedding both over and under infant (not including wrapping blanket):

| Bedding UNDER Infant | None | Number | Bedding OVER Infant | None | Number |
|---------------------------------------|--------------------------|--------|---------------------------------------|--------------------------|--------|
| Receiving blankets | <input type="checkbox"/> | _____ | Receiving blankets | <input type="checkbox"/> | _____ |
| Infant/child blankets | <input type="checkbox"/> | _____ | Infant/child blankets | <input type="checkbox"/> | _____ |
| Infant/child comforters (thick) | <input type="checkbox"/> | _____ | Infant/child comforters (thick) | <input type="checkbox"/> | _____ |
| Adult comforters/duvets | <input type="checkbox"/> | _____ | Adult comforters/duvets | <input type="checkbox"/> | _____ |
| Adult blankets | <input type="checkbox"/> | _____ | Adult blankets | <input type="checkbox"/> | _____ |
| Sheets | <input type="checkbox"/> | _____ | Sheets | <input type="checkbox"/> | _____ |
| Sheepskin | <input type="checkbox"/> | _____ | Pillows | <input type="checkbox"/> | _____ |
| Pillows | <input type="checkbox"/> | _____ | Rubber or plastic sheet | <input type="checkbox"/> | _____ |
| Rubber or plastic sheet | <input type="checkbox"/> | _____ | Other, specify: | _____ | _____ |
| Other, specify: | | | | | |

Which of the following devices were operating in the infant's room?
 None Apnea monitor Humidifier Vaporizer Air Purifier Other _____

24 What was the temperature of the infant's room? Hot Cold Normal Other _____

25 Which of the following items were near the infant's face, nose, or mouth?
 Bumper pads Infant pillows Positional supports Stuffed animals Toys Other _____

26 Which of the following items were within the infant's reach?
 Pacifier Nothing Other _____
 Blankets Toys Pillows _____

27 Was anyone sleeping with the infant? No Yes ⇨ Name these people.

| Name | Age | Height | Weight | Location in Relation to Infant | Impaired (intoxicated, tired) |
|-------|-------|--------|--------|--------------------------------|-------------------------------|
| _____ | _____ | _____ | _____ | _____ | _____ |

28 Was there evidence of wedging? No Yes ⇨ Describe: _____

29 When the infant was found, was s/he: Breathing Not breathing
 If not breathing, did you witness the infant stop breathing? No Yes

WITNESS INTERVIEW (cont.)

30 What had led you to check on the infant?

31 Describe infant's appearance when found.

| | Unknown | No | Yes | Describe and specify location: |
|---|--------------------------|--------------------------|--------------------------|--------------------------------|
| a) Discoloration around face/nose/mouth | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇒ _____ |
| b) Secretions (foam, froth) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇒ _____ |
| c) Skin discoloration (livor mortis) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇒ _____ |
| d) Pressure marks (pale areas, blanching) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇒ _____ |
| e) Rash or petechiae (small, red blood spots on skin, membranes, or eyes) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇒ _____ |
| f) Marks on body (scratches or bruises) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇒ _____ |
| g) Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇒ _____ |

32 What did the infant feel like when found? (Check all that apply.)

| | | |
|---|--|--|
| <input type="checkbox"/> Sweaty | <input type="checkbox"/> Warm to touch | <input type="checkbox"/> Cool to touch |
| <input type="checkbox"/> Limp, flexible | <input type="checkbox"/> Rigid, stiff | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other ⇒ Specify: _____ | | |

33 Did anyone else other than EMS try to resuscitate the infant? No Yes ⇒ Who and when?

Who _____ / _____ / _____ : _____
Month Day Year Military Time

34 Please describe what was done as part of resuscitation:

35 Has the parent/caregiver ever had a child die suddenly and unexpectedly? No Yes ⇒ Explain

INFANT MEDICAL HISTORY

1 Source of medical information:

Mother/primary caregiver Doctor Other healthcare provider Medical record

Family Other: _____

2 In the 72 hours prior to death, did the infant have:

| | Unknown | No | Yes | | Unknown | No | Yes |
|---|--------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|--------------------------|
| a) Fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | h) Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Excessive sweating | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | i) Stool changes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Lethargy or sleeping more than usual | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | j) Difficulty breathing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Fussiness or excessive crying | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | k) Apnea (stopped breathing) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Decrease in appetite | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | l) Cyanosis (turned blue/gray) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Vomiting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | m) Seizures or convulsions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Choking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | n) Other, specify: _____ | | | |

3 In the 72 hours prior to death, was the infant injured or did s/he have any other condition(s) not mentioned?

No Yes ⇒ Describe: _____

4 In the 72 hours prior to the infant's death, was the infant given any vaccinations or medications?

(Please include any home remedies, herbal medications, prescription medicines, over-the-counter medications.)

No Yes ⇒ List below

| Name of vaccination or medication | Dose last given | Date given | | | Approx. time | Reasons given/ comments: |
|-----------------------------------|-----------------|------------|-----|------|--------------|--------------------------|
| | | Month | Day | Year | | |
| 1 _____ | | / | / | / | : | _____ |
| 2 _____ | | / | / | / | : | _____ |
| 3 _____ | | / | / | / | : | _____ |
| 4 _____ | | / | / | / | : | _____ |

INFANT MEDICAL HISTORY (cont.)

5 At any time in the infant's life, did s/he have a history of?

| | Unknown | No | Yes | Describe: |
|---|--------------------------|--------------------------|--------------------------|-----------|
| a) Allergies (food, medication, or other) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇨ _____ |
| b) Abnormal growth or weight gain/loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇨ _____ |
| c) Apnea (stopped breathing) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇨ _____ |
| d) Cyanosis (turned blue/gray) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇨ _____ |
| e) Seizures or convulsions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇨ _____ |
| f) Cardiac (heart) abnormalities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇨ _____ |
| g) Metabolic disorders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇨ _____ |
| h) Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇨ _____ |

6 Did the infant have any birth defects(s)?

No Yes

Describe: _____

7 Describe the two most recent times that the infant was seen by a physician or health care provider:

(Include emergency department visits, clinic visits, hospital admissions, observational stays, and telephone calls)

| | First most recent visit | Second most recent visit |
|---------------------|-------------------------------------|-------------------------------------|
| a) Date | _____/_____/_____ Month Day Year | _____/_____/_____ Month Day Year |
| b) Reason for visit | _____ | _____ |
| c) Action taken | _____ | _____ |
| d) Physician's name | _____ | _____ |
| e) Hospital/clinic | _____ | _____ |
| f) Address | _____ | _____ |
| g) City, ZIP | _____ | _____ |
| h) Phone number | () - _____ | () - _____ |

8 Birth hospital name:

Street _____
City _____ State _____ ZIP _____
Date of discharge ____/____/____
Month Day Year

9 What was the infant's length at birth? _____ inches _____ or _____ centimeters

10 What was the infant's weight at birth? _____ pounds _____ ounces _____ or _____ grams

11 Compared to the delivery date, was the infant born on time, early, or late?

On time Early - How many weeks early? _____ Late - How many weeks late? _____

12 Was the infant a singleton, twin, triplet, or higher gestation?

Singleton Twins Triplet Quadruplet or higher gestation

13 Were there any complications during delivery or at birth? (emergency c-section, child needed oxygen)

No Yes ⇨ Describe the complications: _____

14 Are there any alerts to pathologist? (previous infant deaths in family, newborn screen results)

No Yes ⇨ Specify: _____

INFANT DIETARY HISTORY

1 On what day and at what approximate time was the infant last fed?

____/____/____ : _____
 Month Day Year Military Time

2 What is the name of the person who last fed the infant? _____

3 What is his/her relationship to the infant? _____

4 What foods and liquids was the infant fed in the **last 24 hours** (include last fed)?

| | Unknown | No | Yes | | Quantity | Specify: (type and brand if applicable) |
|---|--------------------------|--------------------------|--------------------------|---|--------------|---|
| a) Breast milk (one/both sides, length of time) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇒ | _____ ounces | _____ |
| b) Formula (brand, water source - ex. Similac, tap water) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇒ | _____ ounces | _____ |
| c) Cow's milk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇒ | _____ ounces | _____ |
| d) Water (brand, bottled, tap, well) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇒ | _____ ounces | _____ |
| e) Other liquids (teas, juices) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇒ | _____ ounces | _____ |
| f) Solids | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇒ | _____ | _____ |
| g) Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ⇒ | _____ | _____ |

5 Was a new food introduced in the 24 hours prior to his/her death?

No Yes ⇒ Describe (ex. content, amount, change in formula, introduction of solids)

6 Was the infant last placed to sleep with a bottle?

Yes No ⇒ Skip to question **9** below

7 Was the bottle propped? (i.e., object used to hold bottle while infant feeds)

No Yes ⇒ What object was used to prop the bottle? _____

8 What was the quantity of liquid (in ounces) in the bottle? _____

9 Did death occur during? Breast-feeding Bottle-feeding Eating solid foods Not during feeding

10 Are there any factors, circumstances, or environmental concerns that may have impacted the infant that have not yet been identified? (ex. exposed to cigarette smoke or fumes at someone else's home, infant unusually heavy, placed with positional supports or wedges)

No Yes ⇒ Describe concerns: _____

PREGNANCY HISTORY

1 Information about the infant's birth mother:

First name _____ Middle name _____

Last name _____ Maiden name _____

Date of birth: _____ / _____ / _____ SS # _____ - _____ - _____
 Month Day Year

Current Address _____ City _____ State _____ ZIP _____

How long has the birth mother been a resident at this address? _____ and _____
 Years Months Previous Address City State

2 At how many weeks or months did the birth mother begin prenatal care?

_____ Weeks _____ Months No prenatal care Unknown

3 Where did the birth mother receive prenatal care? (Please specify physician or other health care provider name and address.)

Physician/provider _____ Hospital/clinic _____ Phone (____) _____ - _____

Street _____ City _____ State _____ ZIP _____

PREGNANCY HISTORY (cont.)

4 During her pregnancy with the infant, did the biological mother have any complications?

(ex. high blood pressure, bleeding, gestational diabetes)

No Yes ⇨ Specify _____

5 Was the biological mother injured during her pregnancy with the infant? (ex. auto accident, falls)

No Yes ⇨ Specify _____

6 During her pregnancy, did she use any of the following?

| | Unknown | No | Yes | Daily consumption | | Unknown | No | Yes | Daily consumption |
|---------------------------------|--------------------------|--------------------------|--------------------------|-------------------|---------------|--------------------------|--------------------------|--------------------------|-------------------|
| a) Over the counter medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | d) Cigarettes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| b) Prescription medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | e) Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| c) Herbal remedies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | f) Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

7 Currently, does any caregiver use any of the following?

| | Unknown | No | Yes | Daily consumption | | Unknown | No | Yes | Daily consumption |
|---------------------------------|--------------------------|--------------------------|--------------------------|-------------------|---------------|--------------------------|--------------------------|--------------------------|-------------------|
| a) Over the counter medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | d) Cigarettes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| b) Prescription medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | e) Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| c) Herbal remedies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | f) Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

INCIDENT SCENE INVESTIGATION

1 Where did the incident or death occur? _____

2 Was this the primary residence? Yes No

3 Is the site of the incident or death scene a daycare or other childcare setting?

Yes No ⇨ Skip to question **8** below

4 How many children were under the care of the provider at the time of the incident or death? _____ (under 18 years or older)

5 How many adults were supervising the child(ren)? _____ (18 years or older)

6 What is the license number and licensing agency for the daycare?

License number: _____ Agency: _____

7 How long has the daycare been open for business? _____

8 How many people live at the site of the incident or death scene?

_____ Number of adults (18 years or older) _____ Number of children (under 18 years old)

9 Which of the following heating or cooling sources were being used? (Check all that apply.)

| | | | |
|--|--|---|---|
| <input type="checkbox"/> Central air | <input type="checkbox"/> Gas furnace or boiler | <input type="checkbox"/> Wood burning fireplace | <input type="checkbox"/> Open window(s) |
| <input type="checkbox"/> A/C window unit | <input type="checkbox"/> Electric furnace or boiler | <input type="checkbox"/> Coal burning furnace | <input type="checkbox"/> Wood burning stove |
| <input type="checkbox"/> Ceiling fan | <input type="checkbox"/> Electric space heater | <input type="checkbox"/> Kerosene space heater | |
| <input type="checkbox"/> Floor/table fan | <input type="checkbox"/> Electric baseboard heat | <input type="checkbox"/> Other ⇨ Specify _____ | |
| <input type="checkbox"/> Window fan | <input type="checkbox"/> Electric (radiant) ceiling heat | <input type="checkbox"/> Unknown | |

10 Indicate the temperature of the room where the infant was found unresponsive:

_____ Thermostat setting _____ Thermostat reading _____ Actual room temp. _____ Outside temp.

11 What was the source of drinking water at the site of the incident or death scene? (Check all that apply.)

Public/municipal water source Bottled water Other ⇨ Specify _____

Well Unknown

12 The site of the incident or death scene has: (check all that apply)

| | | |
|--|--|---|
| <input type="checkbox"/> Insects | <input type="checkbox"/> Mold growth | <input type="checkbox"/> Odors or fumes ⇨ Describe: _____ |
| <input type="checkbox"/> Smoky smell (like cigarettes) | <input type="checkbox"/> Pets | <input type="checkbox"/> Presence of alcohol containers |
| <input type="checkbox"/> Dampness | <input type="checkbox"/> Peeling paint | <input type="checkbox"/> Presence of drug paraphenalia |
| <input type="checkbox"/> Visible standing water | <input type="checkbox"/> Rodents or vermin | <input type="checkbox"/> Other ⇨ Specify _____ |

13 Describe the general appearance of incident scene: (ex. cleanliness, hazards, overcrowding, etc.)

INVESTIGATION SUMMARY

1 Are there any factors, circumstances, or environmental concerns about the incident scene investigation that may have impacted the infant that have not yet been identified?

2 Arrival times: Law enforcement at scene: _____ : _____ Military Time DSI at scene: _____ : _____ Military Time Infant at hospital: _____ : _____ Military Time

Investigator's Notes

Indicate the task(s) performed.

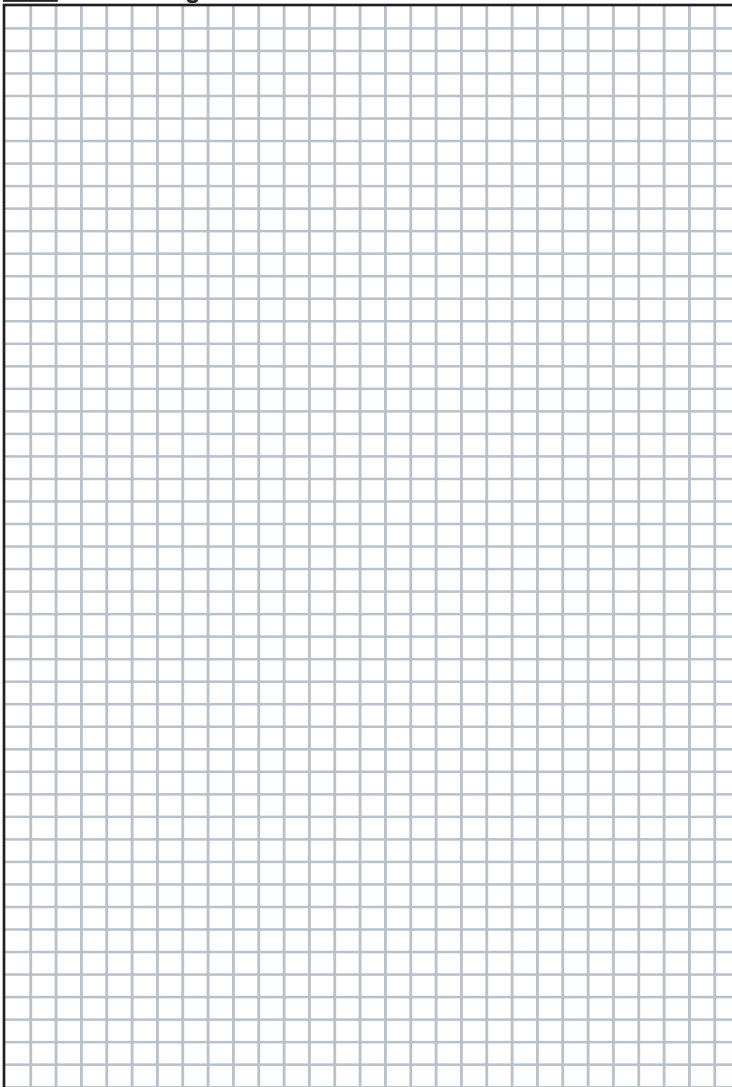
- | | | |
|--|---|--|
| <input type="checkbox"/> Additional scene(s)? (forms attached) | <input type="checkbox"/> Doll reenactment/scene re-creation | <input type="checkbox"/> Photos or video taken and noted |
| <input type="checkbox"/> Materials collected/evidence logged | <input type="checkbox"/> Referral for counseling | <input type="checkbox"/> EMS run sheet/report |
| <input type="checkbox"/> Notify next of kin or verify notification | <input type="checkbox"/> 911 tape | |

If more than one person was interviewed, does the information differ?

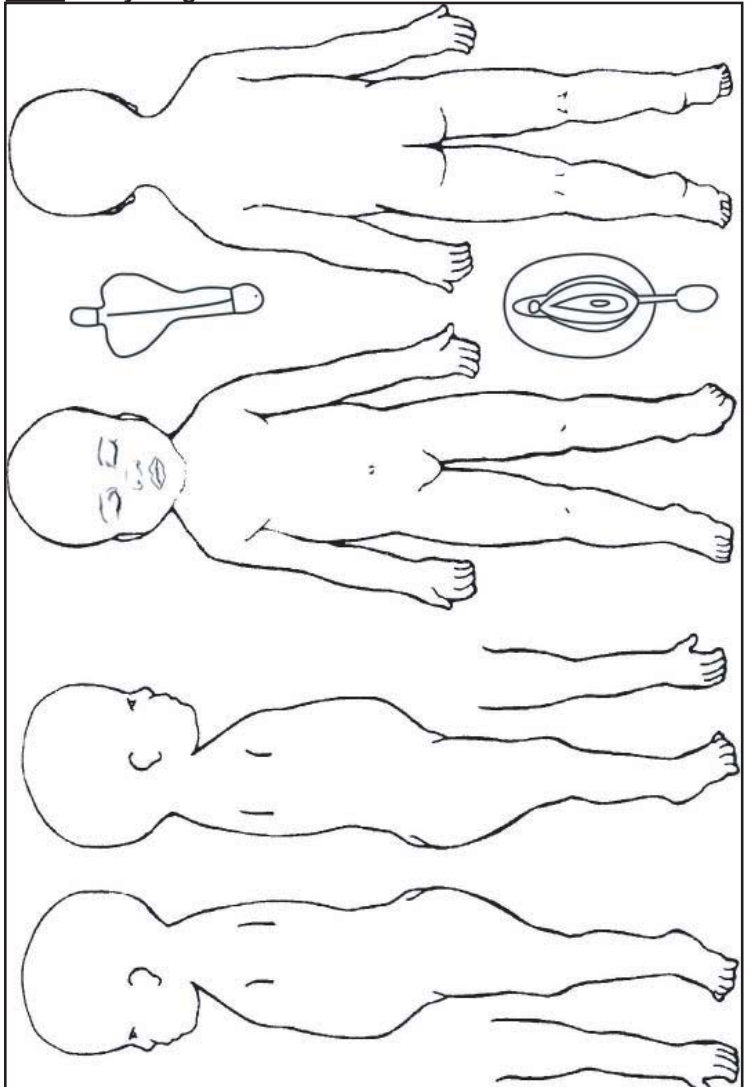
- No Yes ⇨ Detail any differences, inconsistencies of relevant information: (ex. placed on sofa, last known alive on chair.)
-
-
-

INVESTIGATION DIAGRAMS

1 Scene Diagram:



2 Body Diagram:



SUMMARY FOR PATHOLOGIST

Case Information

Investigator Information: Name _____ Agency _____ Phone _____

Investigated: _____ / _____ / _____ : _____ Military Time Pronounced Dead: _____ / _____ / _____ : _____ Military Time
Month Day Year Month Day Year

Infant's Information: Last _____ First _____ M. _____ Case # _____

Sex: Male Female Date of Birth _____ / _____ / _____ Age _____ Months
Month Day Year

Race: White Black/African Am. Asian/Pacific Islander Am. Indian/Alaskan Native Hispanic/Latino Other

Sleeping Environment

1 Indicate whether preliminary investigation suggests any of the following:

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Asphyxia (<i>ex. overlying, wedging, choking, nose/mouth obstruction, re-breathing, neck compression, immersion in water</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | Sharing of sleeping surface with adults, children, or pets |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in sleeping condition (<i>ex. unaccustomed stomach sleep position, location, or sleep surface</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperthermia/Hypothermia (<i>ex. excessive wrapping, blankets, clothing, or hot or cold environments</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | Environmental hazards (<i>ex. carbon monoxide, noxious gases, chemicals, drugs, devices</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | Unsafe sleeping conditions (<i>ex. couch/sofa, waterbed, stuffed toys, pillows, soft bedding</i>) |

Infant History

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Diet (<i>ex. solids introduction etc.</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent hospitalization |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous medical diagnosis |
| <input type="checkbox"/> | <input type="checkbox"/> | History of acute life-threatening events (<i>ex. apnea, seizures, difficult breathing</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | History of medical care without diagnosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent fall or other injury |
| <input type="checkbox"/> | <input type="checkbox"/> | History of religious, cultural, or ethnic remedies |
| <input type="checkbox"/> | <input type="checkbox"/> | Cause of death due to natural causes other than SIDS (<i>ex. birth defects, complications of preterm birth</i>) |

Family Info

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Prior sibling deaths |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous encounters with police or social service agencies |
| <input type="checkbox"/> | <input type="checkbox"/> | Request for tissue or organ donation |
| <input type="checkbox"/> | <input type="checkbox"/> | Objection to autopsy |

Exam

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Pre-terminal resuscitative treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Death due to trauma (injury), poisoning, or intoxication |

Investigator Insight

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Suspicious circumstances |
| <input type="checkbox"/> | <input type="checkbox"/> | Other alerts for pathologist's attention |

Any "Yes" answers should be explained and detailed.

Brief description of circumstances: _____

Pathologist

2 Pathologist Information:

Name _____ Agency _____

Phone (_____) _____ - _____ Fax (_____) _____ - _____