

# 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: \_\_\_\_\_

**5** 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 ( <i>thick</i> ) .....	<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		
<b>1</b> _____		/	/	/	:	_____
<b>2</b> _____		/	/	/	:	_____
<b>3</b> _____		/	/	/	:	_____
<b>4</b> _____		/	/	/	:	_____

## 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?

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**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.

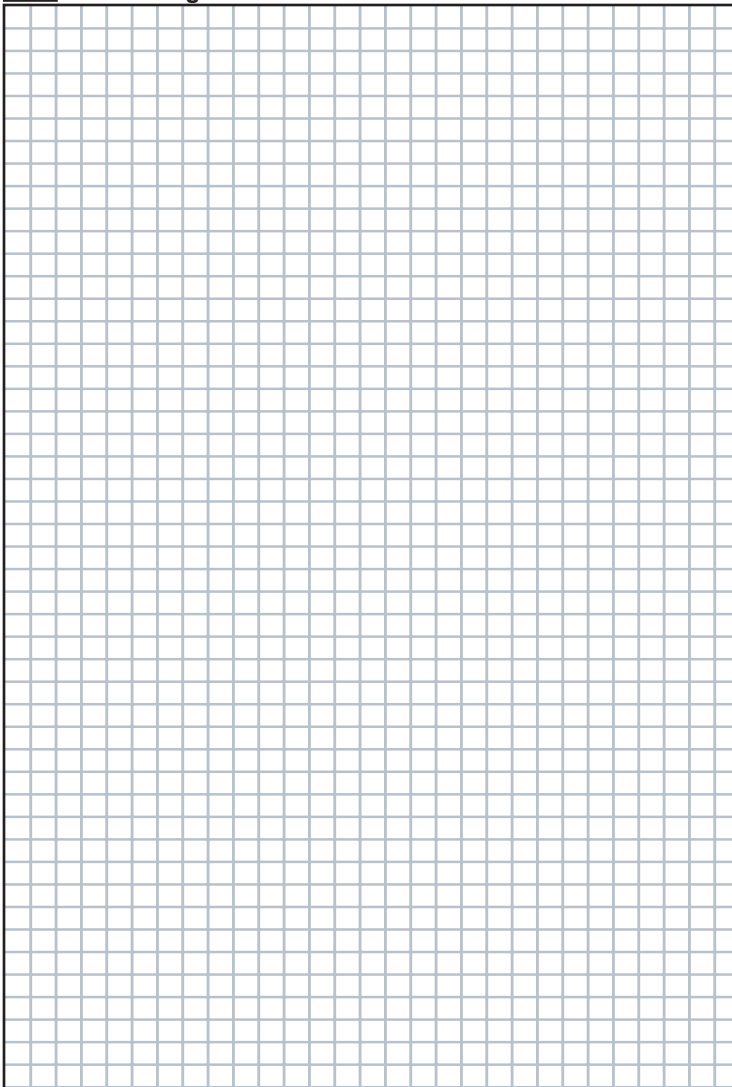
- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Additional scene(s)? (forms attached)     | <input type="checkbox"/> Doll reenactment/scene re-creation | <input type="checkbox"/> Photos or video taken and noted |
| <input type="checkbox"/> Materials collected/evidence logged       | <input type="checkbox"/> 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?

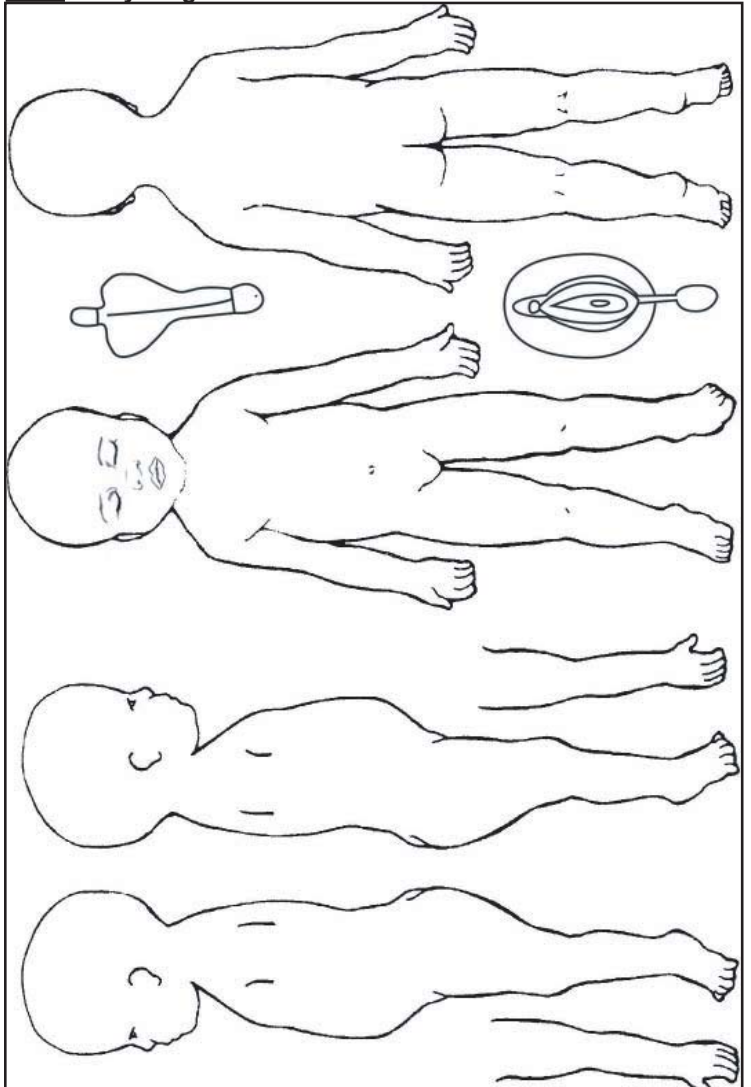
- No  Yes ⇨ Detail any differences, inconsistencies of relevant information: (ex. placed on sofa, last known alive on chair.)
- 
- 
- 

## INVESTIGATION DIAGRAMS

**1** Scene Diagram:



**2** Body Diagram:



**SUMMARY FOR PATHOLOGIST**

**Case Information**

**Investigator Information:** Name \_\_\_\_\_ Agency \_\_\_\_\_ Phone \_\_\_\_\_

Investigated: \_\_\_\_/\_\_\_\_/\_\_\_\_ : \_\_\_\_ Pronounced Dead: \_\_\_\_/\_\_\_\_/\_\_\_\_ : \_\_\_\_  
 Month Day Year Military Time Month Day Year Military Time

**Infant's Information:** Last \_\_\_\_\_ First \_\_\_\_\_ M. \_\_\_\_\_ Case # \_\_\_\_\_

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

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 ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_