

# Sudden Unexpected Infant Death

## Investigation Reporting Form

Recommended for use with infant deaths, less than 12 months of age, that are: 1) "Sudden" referring to the circumstance where the onset of symptoms is within 24 hours or less from death and 2) "Unexpected" referring to individuals considered to be in good health, had a chronic but stable condition, or a new illness not considered to be life threatening.

### INFANT DEMOGRAPHICS

- Infant's Information.** Full name: \_\_\_\_\_ Case number: \_\_\_\_\_  
Sex: ☐ Male ☐ Female Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_  
Race: ☐ White ☐ Black/African Am. ☐ Asian/Pacific Islander ☐ Am. Indian/Alaskan Native ☐ Hispanic/Latino ☐ Other
- Infant's primary residence.** Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### PREGNANCY HISTORY

- Birth mother information.** ☐ Birth mother's information is unavailable Full name: \_\_\_\_\_  
Maiden name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
Current address (if different from infant's primary address): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
☐ Same as infant's primary residence address above  
Email address: \_\_\_\_\_
- How long has the birth mother been at this address?** Years: \_\_\_\_\_ Months: \_\_\_\_\_ Days: \_\_\_\_\_
- Previous address(es) (cities/states/counties) in the past 5 years:** \_\_\_\_\_
- Did the birth mother receive prenatal care?** ☐ Yes ☐ No ☐ Unknown  
If yes: At how many weeks or months did prenatal care begin? \_\_\_\_\_ ☐ Weeks ☐ Months  
Approximately how many prenatal care visits? \_\_\_\_\_
- Where did the birth mother receive prenatal care?**  
Physician/Provider's name: \_\_\_\_\_ Hospital/Clinic name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_
- Did the birth mother have any complications/medical conditions or injuries during her pregnancy?** (e.g., high blood pressure, bleeding, gestational diabetes, fall, accident) ☐ Yes ☐ No ☐ Unknown  
If yes, specify: \_\_\_\_\_
- During her pregnancy, did the birth mother use any of the following?** (indicate yes (Y), no (N), or unknown (UNK) for all that apply)

	Y, N, UNK	Specify Type	Frequency
Over the counter medications			
Prescribed medications			
Herbal remedies			
Alcohol			
Illicit drugs (e.g., heroin)			
Other			
Tobacco (e.g., cigarettes, e-cigarettes)			

1. **Source of infant medical history information.** (*check all that apply*) ☐ Doctor ☐ Other healthcare provider  
☐ Medical record ☐ Parent/primary caregiver ☐ Other family ☐ Other, specify: \_\_\_\_\_
2. **Were there any complications during delivery or at birth?** (*e.g., emergency C-section, infant needed oxygen*)  
☐ Yes ☐ No ☐ Unk **If yes, describe:** \_\_\_\_\_
3. **Did the infant have abnormal newborn screening results?** ☐ Yes ☐ No ☐ Unk **If yes, describe:** \_\_\_\_\_
4. **Infant's length at birth:** \_\_\_\_\_ ☐ IN ☐ CM
5. **Infant's weight at birth:** \_\_\_\_\_ ☐ LBS and OZ ☐ GM
6. **Compared to the due date, when was the infant born?** ☐ Early (before 37 weeks) - How many weeks? \_\_\_\_\_  
☐ Late (after 41 weeks) - How many weeks? \_\_\_\_\_ ☐ On time
7. **Was the infant a singleton or multiple birth?** ☐ Singleton ☐ Twin ☐ Triplet ☐ Quadruplet or higher
8. **Was the infant born with Neonatal Abstinence Syndrome (NAS)?** (NAS is a drug withdrawal syndrome in newborns exposed to substances, like opioids, before birth) ☐ Yes ☐ No ☐ Unknown
9. **What is the contact information for the infant's regular pediatrician and birth hospital?**

	Regular Pediatrician	Birth Hospital
Date	<i>Of last visit:</i>	<i>Of discharge:</i>
Name and hospital/clinic		
Address		
Phone number		

10. **Describe the two most recent times the infant was seen by a healthcare provider (if applicable).** *Include ER and clinic visits, hospital admissions, observational stays, regular pediatrician, and phone calls.*

	1 <sup>st</sup> most recent visit	2 <sup>nd</sup> most recent visit
Reason for visit		
Action taken		
Date		
Physician's name		
Hospital or clinic		
Address		
Phone number		

11. **Did the infant have any of the following?** (*indicate yes (Y), no (N), or unknown (UNK) for all that apply*)

	In last 72 hrs		At any time	In last 72 hrs
Fever		Allergies or allergic reactions ( <i>food, medication, or other</i> )		
Diarrhea		Abnormal growth or weight gain or weight loss		
Excessive sweating		Apnea ( <i>stopped breathing</i> )		
Stool changes		Cyanosis ( <i>turned blue/gray</i> )		
Lethargy or sleeping more than usual		Seizures or convulsions		
Difficulty breathing		Cardiac ( <i>heart</i> ) abnormalities		
Fussiness or excessive crying		Feeding issues ( <i>e.g., reflux, allergies</i> )		
Exposure to anyone who was sick ( <i>e.g., at home, daycare</i> )		Colic ( <i>e.g., frequent prolonged crying, or chronic inconsolable fussiness</i> )		
Decrease in appetite		Vomiting		
Falls/injuries		Choking		
Other, specify:		Other, specify:		

**If yes to any of the above, describe:** \_\_\_\_\_

12. Infant exposed to second hand smoke? (environmental tobacco smoke) ☐ Yes ☐ No ☐ Unknown  
If yes, how often? ☐ Frequently (several times a week) ☐ Occasionally (several times a month) ☐ Unknown
13. In the 72 hours prior to death, was the infant given any vaccinations or medications? (include any home remedies, herbal medications, prescription medicines, over-the-counter medications)

Vaccine or medicine name	Dose last given	Date given (mm/dd/yy)	Approx. time (military)	Reasons given or comments

14. Was the infant last placed to sleep with a bottle? ☐ Yes ☐ No ☐ Unknown  
If yes: Was the bottle propped? (i.e., object used to hold bottle while infant feeds) ☐ Yes ☐ No ☐ Unknown  
If yes: What object propped the bottle?  
Could the infant hold the bottle? ☐ Yes ☐ No ☐ Unknown
15. Who was the last person to feed the infant? (name and relationship to infant) \_\_\_\_\_
16. Did the death occur during feeding? ☐ Breastfeeding ☐ Bottle-Feeding ☐ Eating Solids ☐ Not during feeding
17. Was the infant ever breast fed? ☐ Yes ☐ No ☐ Unknown If yes, how many months? \_\_\_\_\_
18. What did the infant consume in 24 hours prior to death? (if formula mixed with water, check both)

Consumed?	If yes, describe	If yes, newly introduced? Y/N/UNK	If yes, last fed?	If last fed, date and time?	If last fed, indicate quantity
<input type="checkbox"/> Breastmilk	For example, fed from one or both sides of the breast, and length of time baby nursed?				
<input type="checkbox"/> Formula	For example, brand and water source?				
<input type="checkbox"/> Water	For example, brand, bottled, tap, and well?				
<input type="checkbox"/> Other liquids	For example teas, juices, water, and cow's milk?				
<input type="checkbox"/> Solids					
<input type="checkbox"/> Other					

19. Among the infant's blood relatives (siblings, parents, grandparents, aunts or uncles, or first cousins) was there any: Sudden or unexpected death before the age of 50? ☐ Yes ☐ No ☐ Unknown  
Heart disease? (e.g., cardiomyopathy, Marfan or Brugada syndrome, long or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia) ☐ Yes ☐ No ☐ Unknown  
If yes to either, describe: (include relation to infant) \_\_\_\_\_
20. Did the infant have any birth defect(s)? ☐ Yes ☐ No ☐ Unknown If yes, describe: \_\_\_\_\_
21. Was the infant able to roll over on his or her own? (check all that apply) ☐ Front to back ☐ Back to front
22. Indicate infant's ability to lift or hold his or her head up. ☐ Unable ☐ 1 second ☐ 5 seconds ☐ ≥10 seconds ☐ Unknown
23. Was the infant meeting or not meeting growth and developmental milestones (e.g., sitting up, crawling, rolling over, or feeding well)? Include if the caregiver, supervisor, or medical professional had any concerns.  
\_\_\_\_\_  
\_\_\_\_\_
24. Is there anything else that may have affected the infant that has not yet been documented? (e.g., exposed to fumes, infant unusually heavy, placed with positional support or wedge, or international travel) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# INCIDENT SCENE INVESTIGATION (Place infant found unresponsive or dead)

1. Incident location type: (e.g., primary residence, day care, grandma's house) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
2. Was the infant in a new or different environment? (not part of the infant's normal routine) ☐ Yes ☐ No  
☐ Unknown If yes, describe: \_\_\_\_\_
3. Did the death occur at a daycare? ☐ Yes ☐ No ☐ Unknown  
If yes: How many children (under 18 years) were under the care of the provider at the time of the incident or death? (including their own children) \_\_\_\_\_  
How many adults (18 years or older) were supervising the child(ren)? \_\_\_\_\_  
How long has the daycare or school been open for business? \_\_\_\_\_  
Is the daycare licensed? ☐ Yes ☐ No ☐ Unknown  
If yes, License No.: \_\_\_\_\_ Licensing agency: \_\_\_\_\_
4. How many people live at the site of the incident or death scene? Children (under 18) \_\_\_\_\_ Adults (18 or older) \_\_\_\_\_
5. What kind of heating or cooling sources were being used? (e.g., A/C window unit, wood burning fireplace, or open window) \_\_\_\_\_
6. Was there a working carbon monoxide (CO) detector in home? ☐ Yes ☐ No ☐ Unknown
7. Indicate the temperature of the room where the infant was found unresponsive. (fill in temperatures)  
Thermostat setting: \_\_\_\_\_ Thermostat reading: \_\_\_\_\_ Actual room: \_\_\_\_\_ Outside: \_\_\_\_\_ Time of reading: \_\_\_\_\_
8. Which of these devices were operating in the infant's room? (check all that apply) ☐ None ☐ Fan ☐ Apnea monitor  
☐ Humidifier ☐ Vaporizer ☐ Air purifier ☐ Unknown ☐ Other, specify: \_\_\_\_\_
9. What was the source of drinking water at the site of the incident or death scene? (check all that apply)  
☐ Public/municipal water ☐ Bottled water ☐ Well water ☐ Unknown  
☐ Other, specify: \_\_\_\_\_
10. Indicate if the incident site or death scene had obvious indication of any of the following. (check all that apply)  
☐ Insects ☐ Mold growth ☐ Smokey smell ☐ Pets ☐ Dampness ☐ Peeling paint ☐ Visible standing water  
☐ Presence of alcohol containers ☐ None ☐ Rodents or vermin ☐ Odors or fumes, describe: \_\_\_\_\_  
☐ Presence of prescription drugs, describe: \_\_\_\_\_  
☐ Presence of illicit drugs or drug paraphernalia, describe: \_\_\_\_\_  
☐ Other, specify: \_\_\_\_\_
11. Describe the general appearance of incident scene. (e.g., cleanliness, hazards, overcrowding) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
12. Is there anything else that may have affected the infant that has not yet been documented? (e.g., drug and alcohol use at scene, history of domestic violence, child abuse, neglect) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## INCIDENT CIRCUMSTANCES

1. Witness Information. Relationship to deceased. (check all that apply) ☐ Birth mother ☐ Birth father ☐ Grandmother  
☐ Grandfather ☐ Adoptive/foster parent ☐ Physician ☐ Health records ☐ Other, describe: \_\_\_\_\_  
Full Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State/Zip: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Email address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Work address: \_\_\_\_\_
2. Who is the usual caregiver? \_\_\_\_\_
3. Who was the caregiver at the time of incident? (name and relationship to infant) \_\_\_\_\_
4. Tell me what happened. (include details about how the infant was found) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Did you notice anything unusual or different about the infant in the last 24 hours? ☐ Yes ☐ No ☐ Unknown  
If yes, specify: \_\_\_\_\_
6. What was the temperature in the infant's room? ☐ Hot ☐ Cold ☐ Normal ☐ Other  
Did the infant experience any falls or injury in the last 72hrs? ☐ Yes ☐ No ☐ Unknown

7. Was there a crib, bassinet, or portable crib at the place of incidence? ☐ Yes ☐ No ☐ Unknown  
 If yes, was it in good or usable condition? (e.g., not broken or not full of laundry) ☐ Yes ☐ No ☐ Unknown  
 If no, explain: \_\_\_\_\_
8. Where was the infant (L)ast known alive, and (F)ound? (write L and F where appropriate)  
☐ Crib ☐ Portable crib ☐ Waterbed ☐ Stroller ☐ Playpen/play area (not portable crib)  
☐ Bassinet ☐ Sofa/couch ☐ Swing ☐ Futon ☐ Bouncy chair  
☐ Bedside sleeper ☐ Chair ☐ Baby box ☐ Floor ☐ Rocking sleeper  
☐ Car seat ☐ Unknown ☐ Held in person's arms ☐ Other, specify: \_\_\_\_\_  
☐ Adult bed If yes, what type? ☐ Twin ☐ Full ☐ Queen ☐ King ☐ Unknown ☐ Other, specify: \_\_\_\_\_
9. Describe the condition and firmness of the sleep surface: \_\_\_\_\_
10. Were the infant and caregiver in the same room at the time of death, but not sharing the same sleep surface?  
☐ Yes ☐ No ☐ Unknown
11. Was the infant wrapped or swaddled? ☐ Yes ☐ No ☐ Unknown  
 If yes: Describe the arm position? ☐ Arms free and out ☐ Arms in ☐ One arm in and one arm out  
 Describe swaddle: (include blanket type and tightness) \_\_\_\_\_
12. What was the infant wearing? (e.g., t-shirt, disposable diaper) \_\_\_\_\_
13. What was the infant's usual sleep position? ☐ Sitting ☐ Back ☐ Stomach ☐ Side ☐ Unknown
14. Describe circumstances of infant death when last placed by caregiver, last known alive and found.

	Placed	Last Known Alive	Found
Date			
Time			
Location (room)			
Position (e.g., sitting, back, stomach, side, or unknown)			
Face position (e.g., down, up, left, right, or unknown)			
Neck position (e.g., hyperextended or head back, hyperextended or chin to chest, neutral, or turned)			

15. Was the infant's airway obstructed by a person or object when found? (includes obstruction of the mouth or nose, or compression of the neck or chest) ☐ Unobstructed ☐ Fully obstructed ☐ Partially obstructed ☐ Unknown  
 If fully or partially, what was obstructed or compressed? (check all that apply) ☐ Nose ☐ Mouth ☐ Chest ☐ Neck
16. Indicate the items present in the sleep environment vicinity and their relation to the infant when the infant was found.

	Present?			If yes, position in relation to infant?				If yes, did object obstruct the mouth, nose, chest or neck?		
	Yes	No	Unk	Over	Under	Next to	Unk	Yes	No	Unk
Adult(s) (18 years or older)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other child(ren) (under 18 years)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Animal(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mattress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Comforter, quilt, other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fitted sheet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thin blanket	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pillow(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cushion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nursing or u-shaped pillow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep positioner (wedge)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bumper pads	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clothing (not on a person)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crib railing or side	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wall	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Toy(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If yes, to adult(s) or child(ren) sharing sleep surface with the infant, complete table below. ☐ NA

Name of individual(s) sharing sleep surface with infant	Relationship to infant	Age	Height	Weight	Impaired by drugs or alcohol? Y/N/UNK	Fell asleep feeding infant? Y/N/UNK

If yes to impaired, describe: \_\_\_\_\_

17. Was there evidence of wedging? (wedging definition: obstruction of the nose or mouth, or compression of the neck or chest as a result of being stuck or trapped between inanimate objects) ☐ Yes ☐ No ☐ Unknown

If yes, describe: \_\_\_\_\_

18. Was there evidence of overlay? (overlay definition: obstruction of the nose or mouth, or compression of the neck or chest as a result of a person rolling on top of or against an infant) ☐ Yes ☐ No ☐ Unknown

If yes, describe: \_\_\_\_\_

19. Was the infant breathing when found? ☐ Yes ☐ No ☐ Unknown

If no, did anyone witness the infant stop breathing? ☐ Yes ☐ No ☐ Unknown

20. Describe the infant's appearance when found. (indicate all that apply)

	Y/N/UNK	Describe and specify location
Discoloration around face, nose, or mouth		
Secretions or fluids (e.g., foam, froth, urine)		
Skin discoloration (e.g., livor mortis, pale areas, darkness, color changes)		
Pressure marks (e.g., pale areas, blanching)		
Rash or petechiae (e.g., small, red blood spots on skin/membrane/eyes)		
Marks on body (e.g., scratches, bruises)		
Other		

21. What did the infant feel like when found? (check all that apply) ☐ Sweaty ☐ Warm to touch ☐ Cool to touch  
☐ Limp, flexible ☐ Rigid, stiff ☐ Unknown ☐ Other, specify: \_\_\_\_\_

22. Did EMS respond? ☐ Yes ☐ No ☐ Unknown If yes, was the infant transported? ☐ Yes ☐ No ☐ Unknown

23. Was resuscitation attempted? ☐ Yes ☐ No ☐ Unknown

If yes: By whom? (e.g., EMS, bystander, parent) \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Type of compression? (check all that apply) ☐ Two finger ☐ One hand ☐ Two hands

Was rescue breathing done? ☐ Yes ☐ No ☐ Unknown

24. Has the caregiver-at-the-time-of-death ever had a child die suddenly and unexpectedly? ☐ Yes ☐ No ☐ Unknown

If yes, explain: (include familial relationship of child and infant, and cause of death) \_\_\_\_\_

25. Currently, is the infant's caregiver-at-the-time-of-death using any of the following? (indicate all that apply)

	Yes	No	Unk	Frequency
Over the counter medications	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Prescription medications	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Opioids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Cigarettes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Herbal remedies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

Was the infant's caregiver-at-the-time-of-death asked to consent to blood/urine for testing? ☐ Yes ☐ No

☐ Unknown

If yes, what were the results? \_\_\_\_\_



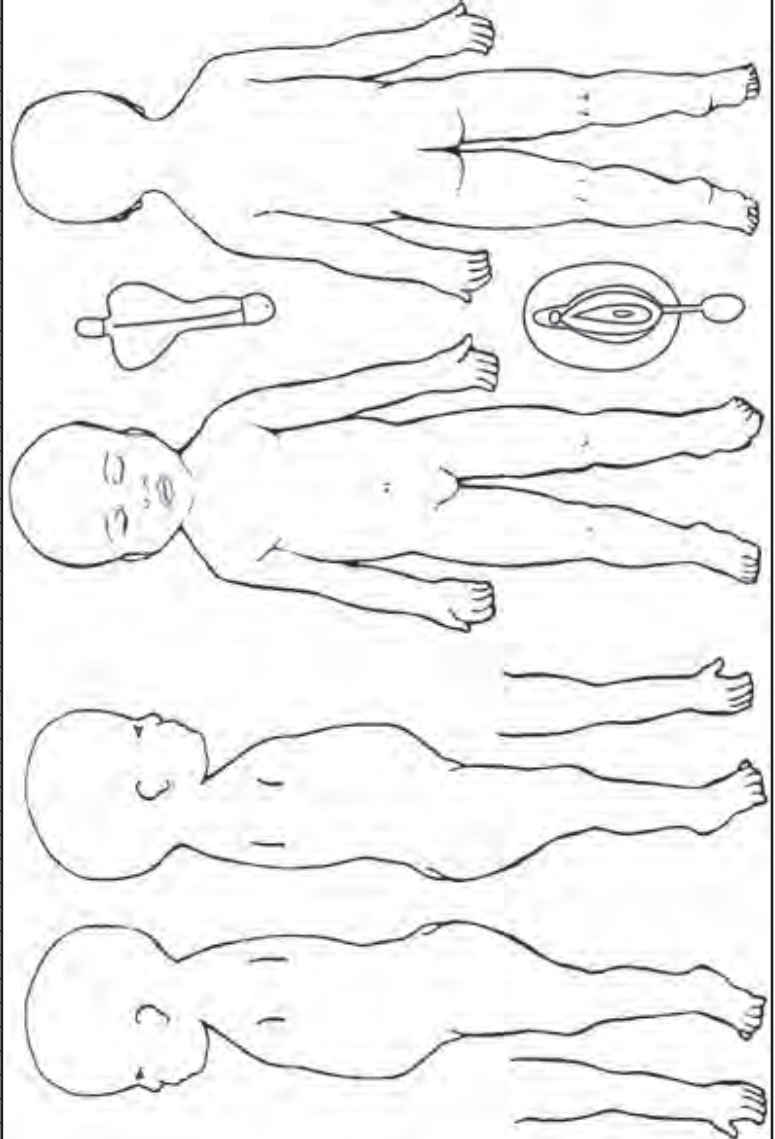
## Arrival dates and times.

	Hospital	Incident Scene
Infant		
Law enforcement		
Death investigator		

1. **Agencies conducting an investigation?** (*check all that apply*) ☐ Child protective services ☐ State police  
☐ Death investigator from medical examiner or coroner office ☐ Local law enforcement  
☐ Other, specify: \_\_\_\_\_
2. **Indicate date and time this form was completed.** \_\_\_\_\_
3. **If more than one person was interviewed, does the information provided differ?** ☐ Yes ☐ No ☐ NA  
**If yes, detail any differences, inconsistencies of relevant information.** (*e.g., placed on sofa, last known alive on chair*)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
4. **Indicate the task(s) performed.** (*check all that apply*) ☐ Additional scene(s) (forms attached) conducted  
☐ Photos or video taken ☐ Materials collected/evidence logged ☐ Next of kin notified ☐ 911 tape obtained  
☐ EMS run sheet or report obtained ☐ Doll reenactment or scene re-creation performed
5. **Was the family offered grief counseling services?** ☐ Yes ☐ No ☐ Unknown  
 Provide "Help For Families" Brochure created at <https://sudc.org/research-medical-info/help-for-families-brochure>
6. **Was a doll scene reenactment performed?** ☐ Yes ☐ No ☐ Unknown  
**If no, why?** \_\_\_\_\_  
**If yes: How was it documented?** ☐ Photographed ☐ Videoed  
**Where was it performed?** ☐ Death scene ☐ Hospital ☐ Other, specify: \_\_\_\_\_  
**Date and time performed:** \_\_\_\_\_  
**Photos/video provided to the pathologist?** ☐ Yes ☐ No ☐ Unknown

**1 Scene Diagram:** Illustrate the child's sleep environment.

**2 Body Diagram:** Note visible injuries, livor, and rigor.



**3. Scene and doll reenactment photos:** include with form.

**SUMMARY FOR PATHOLOGIST**

1. Investigator information. Name: \_\_\_\_\_ Agency: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email address: \_\_\_\_\_
2. Investigated date: \_\_\_\_\_ Time: \_\_\_\_\_
3. Pronounced date: \_\_\_\_\_ Time: \_\_\_\_\_
4. Estimated time of death: \_\_\_\_\_
5. Location of death: (e.g., home or hospital) \_\_\_\_\_
6. Data sources consulted to complete this form (check all that apply) ☐ Infant medical records ☐ Birth records  
☐ Prenatal records ☐ Witness interview ☐ Other, specify: \_\_\_\_\_



**7. Indicate whether preliminary investigation suggests any of the following. (indicate all that apply)**

	Yes	No	
<b>Sleeping Environment</b>	Asphyxia (e.g., evidence of overlying, wedging, choking, nose or mouth obstruction, re-breathing, neck or chest compression, or immersion in water)	<input type="radio"/>	<input type="radio"/>
	Sharing of sleep surface with adults, children, or pets	<input type="radio"/>	<input type="radio"/>
	Change in sleep condition (e.g., unaccustomed stomach sleep position, location, or sleep surface)	<input type="radio"/>	<input type="radio"/>
	Hyperthermia or hypothermia (e.g., excessive wrapping, blankets, clothing, or hot or cold environments)	<input type="radio"/>	<input type="radio"/>
	Environmental hazards (e.g., carbon monoxide, noxious gases, chemicals, drugs, or devices)	<input type="radio"/>	<input type="radio"/>
	Unsafe sleep condition (e.g., non-supine, couch, adult bed, stuffed toys, pillows, or soft bedding)	<input type="radio"/>	<input type="radio"/>
<b>Infant History</b>	Diet (e.g., solids introduced)	<input type="radio"/>	<input type="radio"/>
	Recent hospitalization	<input type="radio"/>	<input type="radio"/>
	Previous medical diagnosis	<input type="radio"/>	<input type="radio"/>
	History of acute life threatening events (e.g., apnea, seizures, or difficulty breathing)	<input type="radio"/>	<input type="radio"/>
	History of medical care without diagnosis	<input type="radio"/>	<input type="radio"/>
	Recent fall or other injury	<input type="radio"/>	<input type="radio"/>
	History of religious, cultural or alternative remedies	<input type="radio"/>	<input type="radio"/>
	Cause of death due to natural causes not SIDS (e.g., birth defects or complications of preterm birth)	<input type="radio"/>	<input type="radio"/>
<b>Family Information</b>	Prior sibling deaths	<input type="radio"/>	<input type="radio"/>
	Sudden/unexpected death before the age of 50 or heart disease (e.g., cardiomyopathy, Marfan or Brugada syndrome, long or short QT syndrome, catecholaminergic polymorphic ventricular tachycardia) among the infant's blood relatives (siblings, parents, grandparents, aunts/uncles or first cousins)	<input type="radio"/>	<input type="radio"/>
	Previous encounters with police or social service agencies	<input type="radio"/>	<input type="radio"/>
	Request for tissue or organ donation	<input type="radio"/>	<input type="radio"/>
	Family interested in participating in research studies, if possible	<input type="radio"/>	<input type="radio"/>
	Objection to autopsy	<input type="radio"/>	<input type="radio"/>
<b>Exam</b>	Pre-terminal resuscitative treatment	<input type="radio"/>	<input type="radio"/>
	Signs of trauma/injury, poisoning, or intoxication	<input type="radio"/>	<input type="radio"/>
	Suspicious circumstances	<input type="radio"/>	<input type="radio"/>

**If yes to any of the above, explain in detail: (description of circumstances)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**8. Medical examiner or pathologist information. Name:** \_\_\_\_\_

**Agency:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Email address:** \_\_\_\_\_

This form is available at <https://sudped.com>