Sudden Unexpected Child Death
Investigation Reporting Form

Recommended for use in pediatric deaths, 12 months and older, 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.

CHILD DEMOGRAPHICS

1. **Child'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
2. **Child's primary residence. Address:** _____
   City: _____ **State:** _____ **Zip:** _____

PREGNANCY HISTORY

1. **Birth mother information.** ☐Birth mother's information is unavailable **Full name:** _____
   Maiden name: _____ **Date of birth:** _____ **SS#:** _____
   Current address *(if different from child's primary address):* _____
   City: _____ **State:** _____ **Zip:** _____
   ☐ Same as child's primary residence address above
   Email address: _____
2. **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: _____
3. **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 ☐Unk **If yes, specify:** _____
4. **Was the birth mother injured during her pregnancy with the child?** ☐No, ☐Yes. **If yes, describe:** _____
   _____
5. **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)			

CHILD'S MEDICAL HISTORY

1. **Source of child 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 child have abnormal newborn screening results?** ▢Yes ▢No ▢Unk **If yes, describe:** _____
4. **Child's length at birth:** _____ ▢IN ▢CM
5. **Child's weight at birth:** _____ ▢LBS and OZ ▢GM
6. **Compared to the due date, when was the child born?** ▢Early (before 37 weeks) - How many weeks? _____ ▢Late (after 41 weeks) - How many weeks? _____ ▢On time
7. **Was the child a singleton or multiple birth?** ▢Singleton ▢Twin ▢Triplet ▢Quadruplet or higher
8. **What is the contact information for the child's regular pediatrician and birth hospital?**

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

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

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

10. **Did the child 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 *(food, medication, or other)*		
Diarrhea		Abnormal growth or weight gain/loss		
Excessive sweating		Apnea *(stopped breathing)*		
Stool changes		Cyanosis *(turned blue/gray)*		
Lethargy or sleeping more than usual		Seizures or convulsions		
Difficulty breathing		Cardiac *(heart)* abnormalities		
Fussiness or excessive crying		Choking		
Exposure to anyone who was sick *(e.g., at home, daycare)*		Feeding issues *(e.g., reflux, allergies)*		
Decrease in appetite		Vomiting		
Falls/injuries		Other, specify:		
Other, specify:				

If yes to any of the above, describe: _____

Are there any photos or videos available that demonstrate the above? (i.e., video of seizure) ▢No ▢Yes

11. Was the child 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

12. In the 72 hours prior to death, was the child given any vaccinations or medications? *(include any home remedies, herbal medications, prescription medicines, over-the-counter medications)*

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

13. Did the child have any birth defect(s)? ☐Yes ☐No ☐Unk **If yes, describe:** _____

14. Has the child been diagnosed with developmental delay or learning disability? ☐No, ☐Yes. **If yes, describe:**

_____

15. Has the child met the appropriate developmental milestones to date? (For children > 5 yrs, skip table)

Milestone	Yes	No	Unknown
Able to walk holding onto things (12m)			
Points to things (12m)			
Able to speak single words (12m)			
Able to walk without assistance (12m)			
Able to walk up steps (18m)			
Drinks from a cup (18m)			
Eats with a spoon (18m)			
Speaks at least 6 words (18m)			
Points to show things to others (18m)			
Says “no” and shakes head (18m)			
Copies what others are doing (2yr)			
Speaks in 2-4 word sentences (2yr)			
Points to pictures or objects when named (2yr)			
Beginning to sort shapes and colors (2yr)			
Throws ball overhand (2yr)			
Beginning to run (2yr)			
Can kick a ball (2yr)			
Dresses and undresses self (3yr)			
Holds 2-3 sentence conversations (3yr)			
Can work a 3-4 piece puzzle (3yr)			
Can walk up steps, one foot per step (3yr)			
Screws/unscrews jar lids and turn door knobs (3yr)			
Catches a bounced ball most of the time (4yr)			
Hops and stands on 1 foot for 2 seconds (4yr)			
Names some colors and numbers (4yr)			
Draws a person with 2-4 body parts (4yr)			
Sings a song or says a poem from memory (4yr)			
Uses a fork and a spoon (5yr)			
Likes to sing/dance/act (5yr)			
Speaks clearly (5yr)			
Says name and address (5yr)			
Can use the toilet by themselves (5yr)			
Stands on one foot for 10 seconds or longer (5yr)			

16. Have there been concerns regarding the child’s ability to interact socially with their peers or others? ☐No, ☐Yes.
If yes, describe: _____

17. Has the child needed, received or been referred for any physical, speech or behavior therapies or interventions?
☐No, ☐Yes. **If yes, describe:** _____

18. Has there been any recent change in the child's behavior, interests or activity level? ☐ No, ☐ Yes. **If yes, describe:** _____

_____

19. Among the child's blood relatives, is there a history of:

	No	Yes	If yes, what relation to child:
Unexplained death			
Sudden explained death- describe			
Unexplained fainting/syncope			
Heart disease or congenital anomalies			
Febrile seizures (6m-6yo during illness/fever)			
Epilepsy or seizure disorder			
Neurological disorder or developmental delay			
Asthma or other respiratory disorders			
Metabolic disorders			
Autoimmune disorders			
Learning disabilities			
Mental illness			
Other:			

20. Is there anything not yet documented that might have affected the child?

_____

CHILD DIETARY HISTORY

1. **Was the child ever breast fed?** ☐ Yes ☐ No ☐ Unknown. **If yes, how many months?** _____
2. **On what day and at what approximate time was the child last fed?** Date: _____ Military time: _____
3. **What is the name of the person who last fed the child?** _____
4. **What is their relationship to the child?** _____
5. **What did the child consume in 24 hours prior to death?** *(if formula mixed with water, check both)*

Consumed?	Unknown	If yes, newly introduced? *Y/N/UNK*	If yes, last fed?	If last fed, date and time?	If last fed, indicate quantity
☐ Breastmilk					
☐ Formula					
☐ Cow's Milk					
☐ Other Milk (soy, lactose free, almond, etc.)					
☐ Water (Bottled, tap, well)					
☐ Juice					
☐ Caffeinated drinks (soda, tea, coffee etc.)					
☐ Solids foods normal for age					
☐ Other					

6. **Did the child have any food restrictions or food sensitivities?** ☐ No, ☐ Yes. **If yes, describe:** _____

_____

7. **Did the child consume a normal diet for his/her age?** ☐ Yes, ☐ No. **If no, describe:** _____

_____

8. **Was a new food introduced in the 24 hours prior to his/her death?** ☐ No, ☐ Yes. **If yes, describe:** (ex. content, amount, date and military time) _____
9. **Any recent change in bowel or bladder habits?** ☐ No, ☐ Yes. **If yes, please describe:** _____

_____

INCIDENT SCENE INVESTIGATION (Place child found unresponsive or dead)

1. **Incident location type:** *(e.g., primary residence, day care, grandma's house)* _____
   Address:_____ **City:**_____ **State:**_____ **Zip:**_____
2. **Did the death occur in a daycare/childcare setting or school?** ▢Yes ▢No ▢Unknown
   If yes: How many children (under 18 years) were under the care of the provider at the time of the incident/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 ▢Unk **If yes, License No.:**_____ **Licensing agency:**_____
   Name of daycare/childcare setting or school _____
3. **How many people live at the site of the incident or death scene?** Children (under 18)_____ Adults (18 or older)_____
4. **What kind of heating or cooling sources were being used?** *(e.g., A/C window unit, wood burning fireplace, open window)* _____
5. **Was there a working carbon monoxide (CO) detector in home?** ▢Yes ▢No ▢Unknown
6. **Indicate the temperature of the room where the child was found unresponsive.** *(fill in temperatures)*
   Thermostat setting:_____ **Thermostat reading:**_____ **Actual room:**_____ **Outside:**_____ **Time of reading:**_____
7. **Which of these devices were operating in the child's room?** *(check all that apply)* ▢None ▢Fan ▢Apnea monitor ▢Humidifier ▢Vaporizer ▢Air purifier ▢Unk ▢Other, specify:_____
8. **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 ▢Unk ▢Other, specify:_____
9. **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:_____
10. **Describe the general appearance of incident scene.** *(e.g., cleanliness, hazards, overcrowding)* _____
11. **Is there anything else that may have impacted the child 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 child)* _____
4. **Tell me what happened.** *(include details about how the child was found)* _____
5. **Did you or anyone witness the terminal event?** ▢**No** ▢**Yes, list name of person:**_____
6. **Apparent activity at the time of the child's terminal event:** ▢**Asleep** ▢**Awake/sedentary** ▢**Exercise** ▢**Unknown**
   Other _____

7. Did you notice anything unusual or different about the child in the last 24 hrs? ◯Yes ◯No ◯Unknown
If yes, specify: _____
Did the child experience any falls or injury in the last 72hrs? ◯Yes ◯No ◯Unknown
If yes, specify: _____
When and where was the child last known alive? Date: _____ Military time: _____ Location(room): _____
Child's activity when last known alive: ◯Asleep ◯Awake/sedentary ◯Exercise ◯Unknown ◯Other: _____
Explain how it was known the child was alive: _____
Child's position when last known alive: ◯Sitting ◯On back ◯On side ◯On stomach ◯Unknown
Was this the child's usual position for last known activity? ◯Yes, ◯No. If no, what was usual position? _____
When and where was the child found? Date: _____ Military time: _____ Location(room): _____
What was the temperature of the location? _____
Child's position when found: ◯Sitting, ◯On back, ◯On side, ◯On stomach, ◯Unknown
Was this the child's usual position for last known activity? ◯Yes, ◯No. If no, what was usual position? _____

8. Where was the child (L)ast known alive, and (F)ound? (write L and F where appropriate)

◯ Crib ◯Portable crib ◯Waterbed ◯Stroller ◯Playpen/play area (not portable crib)
◯ Toddler bed ◯Sofa/couch ◯Twin bed ◯Full bed ◯Queen bed
◯ King bed ◯Chair ◯Mattress/box spring ◯Floor
◯ Car seat ◯Unknown ◯Held in person's arms ◯Other, specify: _____

If incident/death was during apparent sleep, complete questions 9-18

9. Describe the condition and firmness of the sleep surface: _____
10. Face position when last known alive? ◯Face down on surface ◯Face up ◯Face right ◯Face left
11. Face position when found? ◯Face down on surface ◯Face up ◯Face right ◯Face left
12. What was the child wearing? *(e.g., t-shirt, disposable diaper)* _____
13. Was the child bundled? ◯No, ◯Yes. **If yes, please describe:** _____
14. What was the child's usual sleep position? ◯Sitting ◯Back ◯Stomach ◯Side ◯Unknown
15. Was the child'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/compressed? *(check all that apply)* ◯Nose ◯Mouth ◯Chest ◯Neck
16. Indicate the items present in the sleep environment vicinity and their relation to the child when the child 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)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Other child(ren) (under 18 years)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Animal(s)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Mattress	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Comforter, quilt, other	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Fitted sheet	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Thin blanket	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Pillow(s)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Cushion	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Nursing or u-shaped pillow	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Sleep positioner (wedge)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Bumper pads	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Clothing (not on a person)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Crib railing/side	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Wall	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Toy(s)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Other, specify:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

List any of the above items present with quantity greater than one? ◯No, ◯Yes If yes, list item and quantity present _____

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

Name of individual(s) sharing sleep surface with child	Relationship to child	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 ◯Unk **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 a child)* ◯Yes ◯No ◯Unk **If yes, describe:**_____

_____

19. **Was the child breathing when found?** ◯Yes ◯No ◯Unknown
If no, did anyone witness the child stop breathing? ◯Yes ◯No ◯Unknown

20. **Describe the child'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 child 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 child 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 cause of death)*_____

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

	Yes	No	Unk	Frequency
Over the counter medications	☐	☐	☐	_____
Prescription medications	☐	☐	☐	_____
Opioids	☐	☐	☐	_____
Cigarettes	☐	☐	☐	_____
Alcohol	☐	☐	☐	_____
Herbal remedies	☐	☐	☐	_____
Other, specify:	☐	☐	☐	_____

Is there any evidence of parent /caregiver substance abuse? ☐No, ☐Yes, ☐Unknown
Does the parent/caregiver seem impaired at the time of the investigation? ☐No, ☐Yes, ☐Unknown
Was the child's caregiver-at-the-time-of-death asked to consent to blood/urine for testing? ☐Yes ☐No ☐Unknown
If yes, what were the results? _____
Are the clothes of the parent/caregiver available for examination/viewing? ☐No ☐Yes
If yes, are there stains or other significant findings? ☐No, ☐Yes. **If yes, describe:** _____

_____

Does the parent/caregiver/sibling/decedent have any recent social media or cell phone photos or videos of the child?
☐Yes ☐No ☐Unknown
If yes, are they willing to share them with the investigating agency? ☐Yes ☐No

INVESTIGATION SUMMARY

1. **Arrival times. Law enforcement at scene:** _____ **Death investigator at scene:** _____ **Child at hospital:** _____
2. **Are there any factors, circumstances or environmental concerns about the incident scene investigation that may have impacted the child that have not yet been documented?** _____

   _____

   _____
3. **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: _____
4. **Indicate date and time this form was completed.** _____
5. **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)*

   _____

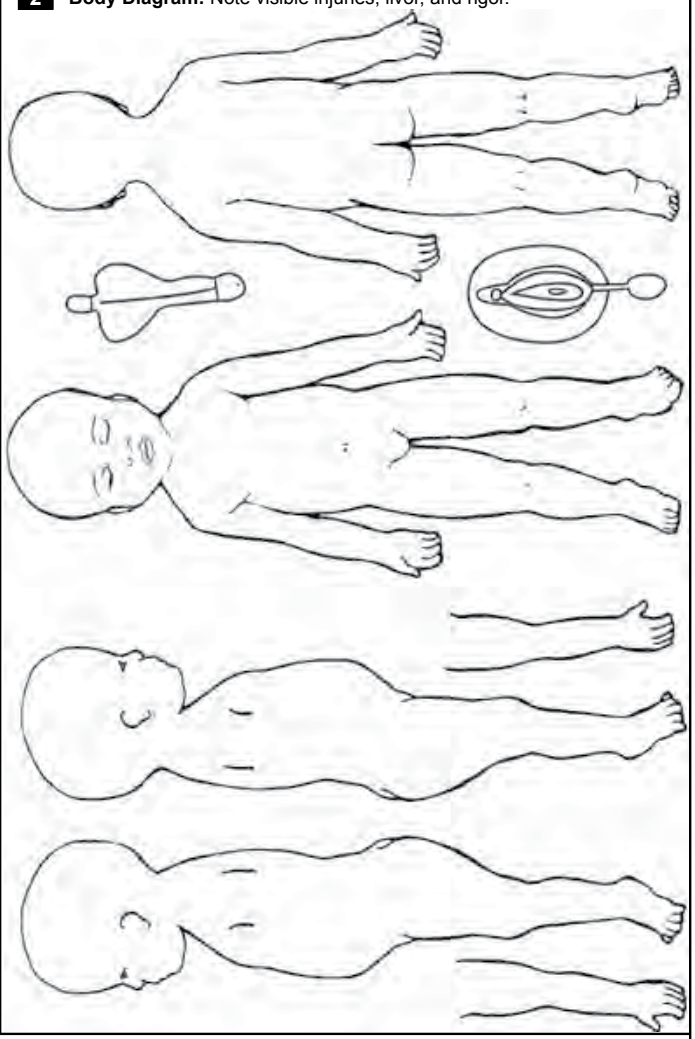
   _____

   _____
6. **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/report obtained ☐Doll reenactment/scene re-creation performed
7. **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
8. **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

INVESTIGATION DIAGRAMS

1 **Scene Diagram:** Illustrate the childs'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:** _____ **Location:** _____ (Home, daycare, hospital etc.)

3. **Pronounced date:** _____ **Time:** _____ **Location:** _____ (Home, daycare, hospital etc.)

4. **Estimated time of death:** _____

5. **Data sources consulted to complete this form** *(check all that apply)* ☐Child medical records ☐Birth records ☐Prenatal records ☐Witness interview ☐Other, specify: _____

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

		Yes	No	N/A
Sleeping Environment	Asphyxia *(e.g., evidence of overlying, wedging, choking, nose/mouth obstruction, re-breathing, neck/chest compression, immersion in water)*	☐	☐	☐
	Sharing of sleep surface with adults, children, or pets	☐	☐	☐
	Change in sleep condition *(e.g., location, or sleep surface)*	☐	☐	☐
	Hyperthermia/hypothermia *(e.g., excessive wrapping, blankets, clothing, or hot or cold environments)*	☐	☐	☐
	Environmental hazards *(e.g., carbon monoxide, noxious gases, chemicals, drugs, devices)*	☐	☐	☐
	Unsafe sleep condition *for developmental age/ability*	☐	☐	☐
Child History	Change in diet/appetite	☐	☐	
	Recent hospitalization	☐	☐	
	Previous medical diagnosis	☐	☐	
	History of acute life threatening events *(e.g., apnea, seizures, difficulty breathing)*	☐	☐	
	History of medical care without diagnosis	☐	☐	
	Recent fall or other injury	☐	☐	
	History of religious, cultural or alternative remedies	☐	☐	
	Potentially lethal natural conditions/illness *(e.g., birth defects, known disorders or infections)*	☐	☐	
Family Information	Prior sibling deaths	☐	☐	
	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 child's blood relatives (siblings, parents, grandparents, aunts/uncles or first cousins)	☐	☐	
	Previous encounters with police or social service agencies	☐	☐	
	Request for tissue or organ donation	☐	☐	
	Family interested in participating in research studies, if possible	☐	☐	
	Objection to autopsy	☐	☐	
Exam	Pre-terminal resuscitative treatment	☐	☐	
	Signs of trauma/injury, poisoning, or intoxication	☐	☐	
	Suspicious circumstances	☐	☐	
	Other alerts for pathologist's attention	☐	☐	

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

_____

_____

_____

_____

_____

7. Pathologist information. Name: _____

Agency: _____

Phone: _____ **Fax:** _____

Email address: _____

This form is available at https://sudpeds.com