

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Disease Control and Prevention Division of Reproductive Health Maternal and Infant Health Branch Atlanta, Georgia 30333





				INVESTIGATION DATA						
Infant's Last	Name	Infant	's First Name	Middle N	lame	Case Number				
x:	Da	ite of Birth:		Age:	SS#:					
ce: White	Black/At	rican Am.	Asian/Pacific Isl.	Am. Indian/Ala	askan Native	Hispanic/Latino C				
nt's Primary Res	idence:				L					
dress:		City	:	County:	State	zip:				
cident dress:		City	:	County:	State	Zip:				
tact Informatio	n for Witness	S:								
lationship to dec	eased:	Birth Mother	r Birth Father	Grandmothe	er Gra	indfather				
Adoptive or Fo	ster Parent	Physicia	an Health I	Records Othe	er Describe:					
st:		First:		M.:	SS#:					
dress:			City:		State:	Zip:				
ork Address:			City:		State:	Zip:				
me Phone:			Work Phone:		Date of					
ine i none.			Work i florie.		NESS INTE					
Did you notic	e anything u	nusual or dif	ferent about the in	fant in the last 24 h	ire?					
No No	Yes	Specify:		idit iii tiio idot 2-7 ii						
Did the infant	experience		igury within the las	t 72 hrs?						
No	Yes	Specify:								
When was the	e infant LAS									
Date:		Military Tim	ne: :	Location (roo	m):					
When was the	infant LAS	KNOWN AL	IVE(LKA)?							
Date:		Military Tim	ne: :	Location (roo	m):					
When was the	infant FOU	ND?								
Date:		Military Tim	ne: :	Location (roo	m):					
Explain how	ou knew the	infant was s	till alive.							
Where was th	e infant - (P)	laced, (L)ast	known alive, (F)ou	nd (write P, L, or F	in front of appro	ppriate response)?				
Bassine	t	Bed	lside co-sleeper	Car seat		Chair				
Cradle		Crib)	Floor		l				
1 1						In a person's arms				
Mattress	/box spring	Mat	tress on floor	Playpen		Portable crib				
Sofa/cou			tress on floor oller/carriage	Playpen Swing		•				

				VVIIIN	IESS INTER	VIEVV (COIIL.	
10	In what position was the infant LAS	Γ PLACED?	Sitting	On back	On side		stomach	Unknown
	Was this the infant's usual position?		Yes	No	What was the	usual po	osition?	
11	In what position was the infant LKA Was this the infant's usual position?	?	Sitting Yes	On back No	On side What was the		stomach osition?	Unknown
40	·							
12	In what position was the infant FOU! Was this the infant's usual position?	ND?	Sitting Yes	On back No	On side What was the		stomach sition?	Unknown
13	Face position when LAST PLACED?	Face	down on su	rface F	ace up	Face rig	ht F	ace left
14	Neck position when LAST PLACED?	Hypere	extended (he	ad back)	Flexed (chin to	chest)	Neutral	Turned
15	Face position when LKA?	ace down on	surface	Face up	Face right	Fa	ace left	
16	Neck position when LKA?	yperextended	d (head back	(x) Flexed	 d (chin to chest)		Neutral	Turned
17	Face position when FOUND?	ace down on	surface	Face up	Face right	Fa	ace left	
18	Neck position when FOUND?	perextended	d (head back	(i) Flexed	d (chin to chest)		Neutral	Turned
19	What was the infant wearing? (ex. t-s	shirt. disposa	able diaper)	,				
20	Was the infant tightly wrapped or sw			Yes - describe:				
21	Please indicate the types and numbe					ot inclu	ding wrappi	ng blanket):
	Bedding UNDER Infant	None	Number	Bedding OVE			None	Number
	Receiving blankets			Receiving blar				
	Infant/child blankets			Infant/child bla				+
	Infant/child comforters (thick)			1	mforters (thick)			
	Adult comforters/duvets			Adult comforte	ers/duvets			
	Adult blankets			Adult blankets	i			
	Sheets			Sheets				
	Sheepskin			Pillows				
	Pillows			Other, specify:				
	Rubber or plastic sheet							
	Other, specify:							
22	Which of the following devices were	operating i	n the infant	's room?				
		umidifier	Vaporizer	Air purifie	or Other -			
23	In was the temperature in the infant'	s room?	Hot	Cold	Normal	Other	_	
24	Which of the following items were no							
	Bumper pads Infant pillows		al supports	Stuffed anir		Oth	ner -	
25	Which of the following items were w		٠. ا		,			
	Blankets Toys Pillows				ther -			
26	Was anyone sleeping with the infant	.? No	Yes	Lagation	a in valation			
	Name of individual sleeping with infant	Age H	eight Weig		n in relation infant	Impairr	ment (intoxio	ation, tired)
27	Was there evidence of wedging?	No	Yes - Descri	be:				
28	When the infant was found, was s/ho			lot Breathing				
	If not breathing, did you witness the inf	ant stop brea	athing?	No Yes				

Appearance Unknown No Yes Describe and specify location							ESS INTERVIE			
a) Discoloration around face/nose/mouth b) Secretions (foam, froth) c) Skin discoloration (livor mortis) d) Pressure marks (pale areas, blanching) e) Rash or petechiae (small, red blood spots on skin, membranes, or eyes) f) Marks on body (scratches or bruises) g) Other 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: Did anyone else other than EMS try to resuscitate the Infant? No Yes Who? Date: Military time: : Please describe what was done as part of resuscitation: No Yes	What had led you to check on the	infant?								
a) Discoloration around face/nose/mouth b) Secretions (foam, froth) c) Skind riscoloration (livor morits) d) Pressure marks (pale areas, blanching) e) Rash or petechiae (small, red blood spots on skin, membranes, or eyes) f) Marks on body (scratches or bruises) g) Other 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: Did anyone else other than EMS try to resuscitate the Infant? No Yes Who? Date: Military time: : Please describe what was done as part of resuscitation: No Yes	Describe the infant's appearance v	when foun	d.							
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3.	Source of medical information: Mother/primary caregiver In the 72 hours prior to death, did Condition a) Fever b) Diarrhea c) Excessive sweating d) Stool changes e) Lethargy or sleeping more than of f) Difficulty breathing g) Fussiness or excessive crying In the 72 hours prior to death, was No Yes - describe: In the 72 hours prior to the infants (Please include any home remedies, here	Other: the infant Ur usual the infant the infant a death, was pal medication	have: alknown tinjured as the inf	or did s	es Co h) i) j) k) n n) s/he h en any edicine	ondition Apnea (s Decrease Cyanosis Vomiting Seizures) Choking Other, sp ave any o	topped breathing in appetite turned blue/gray or convulsions ecify: ther condition(stions or medicate counter medication Approx. time)) not n ions?	Unknown nentioned	No
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INFANT MEDICAL HISTORY (cont.) 5 At any time in the infant's life, did s/he have a history of? Unknown No Medical history Describe a) Allergies (food, medication, or other) b) Abnormal growth or weight gain/loss c) Apnea (stopped breathing) d) Cyanosis (turned blue/gray) e) Seizures or convulsions f) Cardiac (heart) abnormalities 6 Did the infant have any birth defects(s)? No Describe: Describe the two most recent times that the infant was seen by a physician or healthcare provider: (Include emergency department visits, clinic visits, hospital admissions, observational stays, and telephone calls) First most recent visit Second most recent visit a) Date b) Reason for visit c) Action taken d) Physician's name e) Hospital/clinic f) Address g) City h) State, ZIP i) Phone number 8 Birth hospital name: Discharge date: Street address: City: State: Zip: 9 What was the infant's length at birth? inches or centimeters 10 What was the infant's weight at birth? grams pounds ounces or 11 Compared to the delivery date, was the infant born on time, early, or late? On time Early - how many weeks? Late - how many weeks? 12 Was the infant a singleton, twin, triplet, or higher gestation? Singleton Twin Triplet Quadrupelet or higher gestation Were there any complications during delivery or at birth? (emergency c-section, child needed oxygen) No Describe: Are there any alerts to the pathologist? (previous infant deaths in family, newborn screen results) No Specify:

INFANT DIETARY HISTORY On what day and at what approximate time was the infant last fed? 1 Date: 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)? Food Unknown No Yes Quantity (ounces) Specify: (type and brand) a) Breastmilk (one/both sides, length of time) b) Formula (brand, water source - ex. Similac, tap water) c) Cow's milk d) Water (brand, bottled, tap, well) e) Other liquids (teas, juices) f) Solids g) Other 5 Was a new food introduced in the 24 hours prior to his/her death? Yes If yes, describe (ex. content, amount, change in formula, introduction of solids) 6 Was the infant last placed to sleep with a bottle? Yes No - if no, skip to question 9 below 7 Was the bottle propped? (i.e., object used to hold bottle while infant feeds) Nο Yes If yes, what object was used to prop the bottle? What was the quantity of liquid (in ounces) in the bottle? 8 9 Did the death occur during? Breastfeeding 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 If yes, - describe: **PREGNANCY HISTORY** 1 Information about the infant's birth mother: First name: Last name: Middle name: Maiden name: Birth date: SS#: City: Street address: State: Zip: How long has the birth mother been at this address? Years: Months: Previous Address: 2 At how many weeks or months did the birth mother begin prenatal care? Unknown No prenatal care Weeks: Months: 3 Where did the birth mother receive prenatal care? (Please specify physician or other healthcare provider name and address.) Physician/provider: Hospital/clinic: Phone: Street address: City: State: Zip:

Spe	ecify:									
Was	s the birth mother injured du	ıring her pr	egnaı	ncy wi	th the inf	ant? (ex. auto accider	nt, falls)	No	Yes	3
Spe	ecify:									
Duri	ring her pregnancy, did she u	-			_					
2) (Over the counter medications	Unknown	No	Yes	Daily	d) Cigarettes	Unkno	vn No	Yes	Daily
- /	Prescription medications					e) Alcohol				
-	Herbal remedies					f) Other				
Cur	rently, does any caregiver us	se any of tl	he foll	lowing	ı?	1,				
		Unknown		Yes	Daily		Unkno	vn No	Yes	Daily
	Over the counter medications					d) Cigarettes				
-	Prescription medications		-			e) Alcohol				
c) I	Herbal remedies					f) Other				
						INCIDENT SCE	NE INVE	STIG/	NOITA	
Whe	ere did the incident or death	occur?								
				٦,,,						
was	s this the primary residence?	? No		Yes						
le th	he site of the incident or dea	th scene a	dayca	are or	other chi	ildcare setting?	Yes N	lo - If n	o, skip t	o questio
13 (1			-		J	•				
			-				of the inci	dent o	death?	
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INVESTIGATION SUMMARY 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** Military time Law enforcement at scene: DSI at scene: Infant at hospital: **Investigator's Notes** 1 Indicate the task(s) performed Additional scene(s)? (forms attached) Photos or video taken and noted Doll reenactment/scene re-creation Materials collected/evidence logged Referral for counseling EMS run sheet/report Notify next of kin or verify notification 911 tape 2 If more than one person was interviewed, does the information differ? No Yes If 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:**

							SU	MMA	RY FO	R PATH	OLOGI	ST	
Investi	igat	or informa	ation N	lame:			Age	ncy:			Phone:		
				Date	Milit	ary time							
		estigated:				:							
Pron	our	nced dead:				:							
Infant'	s in	formation	: Last:			First:			M:		Case #:		
Sex:		Male	Female	Date	of Birth: [Αg	ge:				
Race:		White	Blad	ck/African	Αm.	Asian	Pacific Islan	der					
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165 1		Asphyxia	(ex. overly	ina. wedaind	a. chokina.	nose/mouth	obstruction, r	e-breatl	hina. neck	compress	ion. immer	sion in wa	ater)
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		Change in	ı sleep co	ndition (ex	. unaccust	tomed stoma	ch sleep posi	tion, loca	ation, or sl	leep surfac	re)		
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		Pre-termin	nal resuso	citative trea	atment								
		Death due	to traum	na (injury),	poisoning	g, or intoxic	ation						
		Suspiciou	s circums	stances									
		Other aler	ts for pat	hologist's a	attention								
Any "	Yes'	' answers a	above sho	ould be exp	olained in	detail (des	cription of c	ircums	tances):				
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