

Infant Death Investigation Checklist

Arizona Report Form, Version 1.0

CHILD

Name:		SSN:
Home Address:		
Incident Address:		
Date of Birth:	Date of Death:	Estimated Time of Death:

MOTHER OR CAREGIVER #1

Name:		Other Names Used:	SSN:
Address:		DL#:	
Date of Birth:	Other States Where Resided:		
Telephone (include area code):		Smoker?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Evidence/History of Substance Use? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Last 24 Hours <input type="checkbox"/> Unknown			

FATHER OR CAREGIVER #2

Name:		Other Names Used:	SSN:
Address:		DL#:	
Date of Birth:	Other States Where Resided:		
Telephone (include area code):		Smoker?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Evidence/History of Substance Use? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Last 24 Hours <input type="checkbox"/> Unknown			

CAREGIVER AT TIME OF DEATH (if other than parent)

Name:		Other Names Used:	SSN:
Address:		DL#:	
Date of Birth:	Other States Where Resided:		
Telephone (include area code):		Smoker?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Evidence/History of Substance Use? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Last 24 Hours <input type="checkbox"/> Unknown			
Relationship to child:		How long cared for child:	

CAREGIVER(S) AT TIME OF DEATH INFORMATION

<p>1. Primary Caregiver Column 1: Secondary Caregiver Column 2:</p> <table style="width: 100%;"> <tr> <td style="width: 50%;"><input type="checkbox"/> One</td> <td style="width: 50%;"><input type="checkbox"/> Two</td> </tr> <tr> <td><input type="checkbox"/> Biological parent</td> <td><input type="checkbox"/> Adoptive parent</td> </tr> <tr> <td><input type="checkbox"/> Step parent</td> <td><input type="checkbox"/> Foster parent</td> </tr> <tr> <td><input type="checkbox"/> Mother's partner</td> <td><input type="checkbox"/> Father's partner</td> </tr> <tr> <td><input type="checkbox"/> Grandparent</td> <td><input type="checkbox"/> Sibling</td> </tr> <tr> <td><input type="checkbox"/> Other relative</td> <td><input type="checkbox"/> Friend/Neighbor</td> </tr> <tr> <td><input type="checkbox"/> Unknown</td> <td><input type="checkbox"/> Daycare Provider</td> </tr> <tr> <td><input type="checkbox"/> Licensed</td> <td><input type="checkbox"/> Unlicensed</td> </tr> <tr> <td><input type="checkbox"/> Other Specify:</td> <td></td> </tr> </table>	<input type="checkbox"/> One	<input type="checkbox"/> Two	<input type="checkbox"/> Biological parent	<input type="checkbox"/> Adoptive parent	<input type="checkbox"/> Step parent	<input type="checkbox"/> Foster parent	<input type="checkbox"/> Mother's partner	<input type="checkbox"/> Father's partner	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other relative	<input type="checkbox"/> Friend/Neighbor	<input type="checkbox"/> Unknown	<input type="checkbox"/> Daycare Provider	<input type="checkbox"/> Licensed	<input type="checkbox"/> Unlicensed	<input type="checkbox"/> Other Specify:		<p>2. Caregiver(s) age in years One Two _____ # years <input type="checkbox"/> <input type="checkbox"/> Unknown</p> <p>3. Caregiver(s) Sex: One Two <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown</p> <p>4. Caregiver(s) employment status: One Two <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> On disability <input type="checkbox"/> Stay-at-home <input type="checkbox"/> Retired <input type="checkbox"/> Unknown</p>	<p>5. Caregiver(s) substance use history One Two <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown If yes, check all that apply <input type="checkbox"/> Alcohol <input type="checkbox"/> Cocaine <input type="checkbox"/> Marijuana <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Opiates <input type="checkbox"/> Prescriptions <input type="checkbox"/> Over the counter <input type="checkbox"/> Unknown <input type="checkbox"/> Other, Specify:</p>	<p>6. Caregiver(s) have prior child death: One Two <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown If yes, cause(s) Check all that apply <input type="checkbox"/> Abuse #____ <input type="checkbox"/> Neglect #____ <input type="checkbox"/> Accident #____ <input type="checkbox"/> Suicide #____ <input type="checkbox"/> SIDS #____ <input type="checkbox"/> Unknown #____ <input type="checkbox"/> Other #____</p>
<input type="checkbox"/> One	<input type="checkbox"/> Two																				
<input type="checkbox"/> Biological parent	<input type="checkbox"/> Adoptive parent																				
<input type="checkbox"/> Step parent	<input type="checkbox"/> Foster parent																				
<input type="checkbox"/> Mother's partner	<input type="checkbox"/> Father's partner																				
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Sibling																				
<input type="checkbox"/> Other relative	<input type="checkbox"/> Friend/Neighbor																				
<input type="checkbox"/> Unknown	<input type="checkbox"/> Daycare Provider																				
<input type="checkbox"/> Licensed	<input type="checkbox"/> Unlicensed																				
<input type="checkbox"/> Other Specify:																					

MEDICAL EXAMINERS OFFICE FAX NUMBERS

- | | |
|--------------------------------|----------------------------------|
| <u>Apache</u> (866) 593-6192 | <u>Maricopa</u> (602) 506-1546 |
| <u>Cochise</u> (520) 724-8610 | <u>Mohave</u> (928) 505-5889 |
| <u>Coconino</u> (928) 779-7056 | <u>Navajo</u> (928) 532-6054 |
| <u>Gila</u> (928) 474-1658 | <u>Pima</u> (520) 724-8610 |
| <u>Graham</u> (928) 348-4033 | <u>Pinal</u> (520) 866-7296 |
| <u>Greenlee</u> (520) 724-8610 | <u>Santa Cruz</u> (520) 724-8610 |
| <u>La Paz</u> (520) 724-8610 | <u>Yavapai</u> (928) 771-3504 |
| | <u>Yuma</u> (928) 336-1608 |

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Incident State: <input type="checkbox"/> Arizona <input type="checkbox"/> Other, Specify _____	Was 911 or local emergency number called? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	CPR performed before EMS arrived? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	During resuscitation was child: <input type="checkbox"/> Injured <input type="checkbox"/> Shaken <input type="checkbox"/> Jostled <input type="checkbox"/> Other, specify: _____	EMS responded to scene? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	Child's activity at time of incident, check all that apply: <input type="checkbox"/> Sleeping <input type="checkbox"/> Unknown <input type="checkbox"/> Playing <input type="checkbox"/> Other <input type="checkbox"/> Working Specify: _____ <input type="checkbox"/> Eating <input type="checkbox"/> In vehicle	Total number of deaths at incident event: Children (Ages 0-18): _____ Adults: _____ <input type="checkbox"/> Unknown
Incident County: _____						

What led someone to check on the infant? _____

Who was in the home when the child was found? _____

Describe child's appearance when found:	No	Yes	Unknown	Describe/specify location:	First Assessed by:
Discoloration around face/nose/mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> EMS
Secretions (foam, froth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> ER
Skin discoloration (livor mortis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> PD
Pressure marks (pale areas, blanching)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Rash or petechiae (small, red blood spots on skin, membranes, or eyes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Marks on body (scratches or bruises)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Infant moved prior to being found	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Time frame information:
 Time Found _____ Last Seen Alive _____ Time Police Called _____ Call Type: 911 Regular Other, specify: _____
 Last Feeding Time _____ Person Calling _____

What did the child feel like when found? (check all that apply)
 Sweaty Warm to touch Cool to touch **Surface body temperature:**
 Limp, flexible Rigid, stiff Unknown **Temperature at hospital:**
 Other, Specify: _____

SUFFOCATION/ASPHYXIA

A. Type of Event <input type="checkbox"/> Suffocation, go to B. <input type="checkbox"/> Strangulation, go to C. <input type="checkbox"/> Choking, go to D.	B. If suffocation/asphyxia, action causing event: <input type="checkbox"/> Sleep-related (e.g. bedding, overlay, wedged) <input type="checkbox"/> Confined in tight space <input type="checkbox"/> Covered in or fell into object, not sleep related <input type="checkbox"/> Refrigerator/freezer <input type="checkbox"/> Plastic bag <input type="checkbox"/> Toy chest <input type="checkbox"/> Dirt/Sand <input type="checkbox"/> Automobile <input type="checkbox"/> Unknown <input type="checkbox"/> Trunk <input type="checkbox"/> Other, Specify: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Other, Specify: _____
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C. If strangulation, object causing event: <input type="checkbox"/> Clothing <input type="checkbox"/> High chair <input type="checkbox"/> Electrical cord <input type="checkbox"/> Blind cord <input type="checkbox"/> Belt <input type="checkbox"/> Automobile power window or sunroof <input type="checkbox"/> Car seat <input type="checkbox"/> Rope/string <input type="checkbox"/> Unknown <input type="checkbox"/> Person <input type="checkbox"/> Stroller <input type="checkbox"/> Leash <input type="checkbox"/> Other, Specify: _____	D. If choking, object causing choking: <input type="checkbox"/> Food, Specify: _____ <input type="checkbox"/> Toy, Specify: _____ <input type="checkbox"/> Balloon <input type="checkbox"/> Unknown <input type="checkbox"/> Other, Specify: _____
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OTHER CIRCUMSTANCES OF INCIDENT – ANSWER RELEVANT SECTIONS

DID DEATH OCCUR WHILE CHILD SLEEPING OR IN A SLEEPING ENVIRONMENT? No Yes

A. INCIDENT sleep place: <input type="checkbox"/> Crib <input type="checkbox"/> Playpen <input type="checkbox"/> Car seat/Stroller <input type="checkbox"/> Bassinette <input type="checkbox"/> Couch <input type="checkbox"/> Unknown <input type="checkbox"/> Adult bed <input type="checkbox"/> Chair <input type="checkbox"/> Other, Specify: _____ <input type="checkbox"/> Waterbed <input type="checkbox"/> Floor	If adult bed, What type? <input type="checkbox"/> Twin <input type="checkbox"/> King <input type="checkbox"/> Full <input type="checkbox"/> Unknown <input type="checkbox"/> Queen <input type="checkbox"/> Other, Specify: _____	C. Child put to sleep: <input type="checkbox"/> On back <input type="checkbox"/> On Stomach <input type="checkbox"/> On side <input type="checkbox"/> Unknown By Whom: _____	D. Child found: <input type="checkbox"/> On back <input type="checkbox"/> On Stomach <input type="checkbox"/> On side <input type="checkbox"/> Unknown By Whom: _____
E. Was there a crib, bassinette, or port-a-crib in home for child? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown			
F. USUAL sleep place: <input type="checkbox"/> Crib <input type="checkbox"/> Playpen <input type="checkbox"/> Car seat/Stroller <input type="checkbox"/> Bassinette <input type="checkbox"/> Couch <input type="checkbox"/> Unknown <input type="checkbox"/> Adult bed <input type="checkbox"/> Chair <input type="checkbox"/> Other, Specify: _____ <input type="checkbox"/> Waterbed <input type="checkbox"/> Floor	If adult bed, what type? <input type="checkbox"/> Twin <input type="checkbox"/> King <input type="checkbox"/> Full <input type="checkbox"/> Unknown <input type="checkbox"/> Queen <input type="checkbox"/> Other, Specify: _____	G. USUAL sleep position: <input type="checkbox"/> On back <input type="checkbox"/> On Stomach <input type="checkbox"/> On side <input type="checkbox"/> Unknown	H. Child in new or different environment? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown

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CIRCUMSTANCES when child found:

<p>Child's airway was:</p> <input type="checkbox"/> Unobstructed by person or object <input type="checkbox"/> Fully obstructed by person or object <input type="checkbox"/> Partially obstructed by person or object <input type="checkbox"/> Unknown	<p>Child's position most relevant to death:</p> <input type="checkbox"/> On top of <input type="checkbox"/> Under <input type="checkbox"/> Between <input type="checkbox"/> Wedged into <input type="checkbox"/> Pressed into <input type="checkbox"/> Fell or rolled onto <input type="checkbox"/> Tangled in <input type="checkbox"/> Unknown <input type="checkbox"/> Other, Specify: _____	<p>With what objects or persons? Check all that apply:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Adult</td> <td><input type="checkbox"/> Waterbed mattress</td> <td><input type="checkbox"/> Clothing</td> </tr> <tr> <td><input type="checkbox"/> Child(ren)</td> <td><input type="checkbox"/> Air mattress</td> <td><input type="checkbox"/> Cord</td> </tr> <tr> <td><input type="checkbox"/> Animal(s)</td> <td><input type="checkbox"/> Pillow-top mattress</td> <td><input type="checkbox"/> Plastic bag</td> </tr> <tr> <td><input type="checkbox"/> Blanket</td> <td><input type="checkbox"/> Crib rail</td> <td><input type="checkbox"/> Wall</td> </tr> <tr> <td><input type="checkbox"/> Pillow</td> <td><input type="checkbox"/> Couch</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Comforter</td> <td><input type="checkbox"/> Car seat/stroller</td> <td><input type="checkbox"/> Other, Specify: _____</td> </tr> <tr> <td><input type="checkbox"/> Mattress</td> <td><input type="checkbox"/> Stuffed toy</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Bumper pads</td> <td><input type="checkbox"/> Chair, Type: _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Adult	<input type="checkbox"/> Waterbed mattress	<input type="checkbox"/> Clothing	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Air mattress	<input type="checkbox"/> Cord	<input type="checkbox"/> Animal(s)	<input type="checkbox"/> Pillow-top mattress	<input type="checkbox"/> Plastic bag	<input type="checkbox"/> Blanket	<input type="checkbox"/> Crib rail	<input type="checkbox"/> Wall	<input type="checkbox"/> Pillow	<input type="checkbox"/> Couch	<input type="checkbox"/> Unknown	<input type="checkbox"/> Comforter	<input type="checkbox"/> Car seat/stroller	<input type="checkbox"/> Other, Specify: _____	<input type="checkbox"/> Mattress	<input type="checkbox"/> Stuffed toy		<input type="checkbox"/> Bumper pads	<input type="checkbox"/> Chair, Type: _____	
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<input type="checkbox"/> Bumper pads	<input type="checkbox"/> Chair, Type: _____																									

Child sleeping on same surface with person(s) or animal(s)? Check all that apply:

<input type="checkbox"/> With adults: Number: _____	Adult obese: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	Alcohol/Drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> With other child(ren): Number: _____	Child(ren)'s ages: _____	
<input type="checkbox"/> With animal(s): Number: _____	Type(s) of animals: _____	
<input type="checkbox"/> Unknown	<input type="checkbox"/> Number Unknown	

What food/liquids was the child fed in the <u>last 24 hours</u> ?	No	Yes	Unknown	Quantity (Specify type & brand, if applicable)
Breast milk (one/both sides, length of time)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ounces
Formula (brand, water source – ex. Similac, tap water)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ounces
Was the formula mixed according to directions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cow's milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ounces
Water (brand, bottled, tap, well)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ounces
Other liquids (juices, teas)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ounces
Solids, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ounces
Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ounces

Was a new food introduced in the 24 hours prior the child's death?
 No Yes Unknown If yes, describe: _____

Was the child last placed to sleep with a bottle?
 No Yes Unknown **How was formula prepared:** _____

Was the bottle propped on object while feeding?
 No Yes Unknown If yes, what object used? _____

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

Did the death occur during:

<input type="checkbox"/> Breastfeeding	<input type="checkbox"/> Bottle feeding	<input type="checkbox"/> Eating solid foods	<input type="checkbox"/> Not during feeding
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RECENT MEDICAL HISTORY

Source of medical information:
 Mother/primary care giver Family Doctor Medical records Other healthcare provider Other, Specify: _____

In the 72 hours prior to death, did the child have: (check all that apply)

	No			Yes			Unknown		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Excessive sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Weakness or sleeping more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough/wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Fussiness or excessive crying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Apnea (stopping breathing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Decrease in appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cyanosis (turned blue/gray)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Choking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other, Specify: _____					

In the 72 hours prior to death, was the child injured or did child have any other condition(s) not mentioned?
 No Yes If yes, describe: _____

In the 72 hours prior to the death, did the child receive any vaccinations, medications, or exposure to any chemicals?
 (Please include any home remedies, herbal medications, prescription medicines or over-the-counter medications including "cough, cold medicine")
 No Yes If yes, describe/list: _____

Any recent visit to a medical provider?
 No Yes If yes, When? _____ Doctor/Facility: _____ Why? _____

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HEALTH INFORMATION

Child's Primary Care Physician:		Phone: ()	Last Visit: When?	Why:
Allergies:		Birth defects:		
Medications:				
Has the child been immunized? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		Date of last immunization:		
Immunizations current? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown If immunized within the last 30 days, specify type:				
Does the child use any home monitors? <input type="checkbox"/> No <input type="checkbox"/> Yes Type/Brand:				
If Yes, was child on home monitor at time of death? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Anyone else in household or other contacts (e.g. daycare) recently ill? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Family history of genetic/inheritable disease(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes, Specify:				

BIRTH INFORMATION

Birth place (home, hospital name and location):				
Birth complications? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify:				
Gestational Age	Birth Weight:	Multiple Birth?	# of prenatal visits	Month of first prenatal visit
<input type="checkbox"/> Unknown _____ weeks	<input type="checkbox"/> Unknown _____ grams _____ pounds/ounces	<input type="checkbox"/> No <input type="checkbox"/> Yes, # _____	<input type="checkbox"/> Unknown # _____	Specify 1-9: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None

During pregnancy, did mother (check all that apply):				
<input type="checkbox"/> Smoke tobacco	<input type="checkbox"/> Experience intimate partner violence	<input type="checkbox"/> Heavy alcohol use	<input type="checkbox"/> Misuse OTC or prescription drugs	
<input type="checkbox"/> Use illicit drugs	<input type="checkbox"/> Child born drug exposed	<input type="checkbox"/> Child born with fetal alcohol effects or syndrome		
<input type="checkbox"/> During pregnancy, did mother have medical complications/infections? (check all that apply) Specify type, if known				
		Type		
<input type="checkbox"/> Lung Disease	_____		<input type="checkbox"/> Preterm Labor	_____
<input type="checkbox"/> Heart Disease	_____		<input type="checkbox"/> Premature Rupture Membrane	_____
<input type="checkbox"/> Blood Disorder	_____		<input type="checkbox"/> Vaginal Bleeding	_____
<input type="checkbox"/> Infectious Disease	_____		<input type="checkbox"/> Diabetes Mellitus	_____
<input type="checkbox"/> Familial Genetic Disorder	_____		<input type="checkbox"/> Other	_____
Were there access or compliance issues related to prenatal care?				
<input type="checkbox"/> No	<input type="checkbox"/> Lack of money for care	<input type="checkbox"/> Religious objections to care		
<input type="checkbox"/> Yes	<input type="checkbox"/> Limited or no health insurance coverage	<input type="checkbox"/> Cultural differences		
If yes, check all that apply:		<input type="checkbox"/> Lack of transportation	<input type="checkbox"/> Unwilling to obtain care	
<input type="checkbox"/> Unknown	<input type="checkbox"/> Lack of child care	<input type="checkbox"/> Did not know care needed		
	<input type="checkbox"/> No phone	<input type="checkbox"/> Other, specify:		

SCENE DOCUMENTATION

Photos of Death Scene Taken? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Property Seized? <input type="checkbox"/> No <input type="checkbox"/> Yes		What Agency Seized Property?		
Formula? <input type="checkbox"/> No <input type="checkbox"/> Yes	Bottles/Contents? <input type="checkbox"/> No <input type="checkbox"/> Yes	Bedding? <input type="checkbox"/> No <input type="checkbox"/> Yes	Crib? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Other, Specify:				
Was there an open CPS case with child at time of death?		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unk		
Was the child ever placed outside of the home prior to death?		<input type="checkbox"/> No <input type="checkbox"/> Yes Date of Placement:		
Were any siblings placed outside of the home prior to this child's death?		<input type="checkbox"/> No <input type="checkbox"/> Yes Date of Placement:		

PERSON COMPLETING FORM

Name (please print or type):		
Agency:		
Telephone: ()	Fax: ()	Date:
Signature:	Date Signed:	

ADDITIONAL COMMENTS: (Include information about additional caregivers/supervisors or circumstances. Attach additional pages as necessary)