Sudden Unexpected Infant Death Investigation
Reporting Form

For use during the investigation of infant (under 1 year of age) deaths that are sudden, unexpected, and unexplained prior to investigation.

INFANT DEMOGRAPHICS

1. **Infant information.** Full name: _____ Date of birth: *(mm/dd/yyyy)* _____

   Age: _____ SS#: _____ Case number: _____

   Primary residence address: _____

   City: _____ State: _____ Zip: _____

2. Race: ◯ White ◯ Black/African Am. ◯ Asian/Pacific Islander ◯ Am. Indian/Alaskan Native ◯ Hispanic/Latino ◯ Other
3. Sex: ◯ Male ◯ Female

PREGNANCY HISTORY

1. **Birth mother information.** ☐ Unavailable Full name: _____

   Maiden name: _____ Date of birth: *(mm/dd/yyyy)* _____ SS#: _____

   Current address: _____

   ☐ Same as infant's primary residence address above City: _____

   State: _____ Zip: _____ Email address: _____

2. How long has the birth mother been at this address? Years: _____ Months: _____ Days: _____
3. Previous address(es) *(cities/counties/states)* in the past 5 years:

   _____

4. Did the birth mother receive prenatal care? ◯ Yes ◯ No ◯ Unknown

   If yes: At how many weeks or months did prenatal care begin? _____ Weeks _____ Months

   How many prenatal care visits were completed? _____

5. Where did the birth mother receive prenatal care? Physician/Provider: _____

   Hospital or Clinic: _____ Phone: _____

   Address: _____

   City: _____ State: _____ Zip: _____

6. Did the birth mother have any complications, medical conditions, or injuries during her pregnancy? ◯ Yes ◯ No ◯ Unknown
   (e.g., high blood pressure, bleeding, gestational diabetes, fall, or accident)

   If yes, describe:

CS310043

7. During her pregnancy, did the birth mother use any of the following?

Substance	Use	Specify Type	Frequency
Over the counter medications	◯Yes ◯No ◯Unknown		
Prescribed medications	◯Yes ◯No ◯Unknown		
Herbal remedies	◯Yes ◯No ◯Unknown		
Alcohol	◯Yes ◯No ◯Unknown		
Illicit drugs *(e.g., heroin)*	◯Yes ◯No ◯Unknown		
Tobacco *(e.g., cigarettes or e-cigarettes)*	◯Yes ◯No ◯Unknown		
Other	◯Yes ◯No ◯Unknown		

INFANT HISTORY

1. Source of infant medical history information. *(check all that apply)*

   ☐ Doctor ☐ Other health care provider ☐ Medical record ☐ Parent or primary caregiver ☐ Other family member

   ☐ Other, specify: _____

2. Were there any complications during delivery or at birth? *(e.g., emergency C-section, or infant needed oxygen)*

   ◯Yes ◯No ◯Unknown *If yes*, describe: _____

3. Did the infant have abnormal newborn screening results? ◯Yes ◯No ◯Unknown

   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)* ◯Late *(after 41 weeks)* ◯On time How many weeks? ____ Infant's due date: *(mm/dd/yyyy)* _____

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

   If yes, did the infant need pharmacologic treatment? ◯Yes ◯ No ◯ Unknown

9. Fill out the contact information for the infant's regular pediatrician and birth hospital.

Item	Regular Pediatrician	Birth Hospital
Date	*Of last visit:* _____	*Of discharge:* _____
Name of hospital or clinic		
Address		
Phone number		

10. Describe the two most recent times the infant was seen by a health care provider.
(include ER and clinic visits, hospital admissions, observational stays, regular pediatrician, and phone calls)

Visit type	1st most recent visit	2nd 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?

Symptom	Within 72 hrs of incident
Fever	◯ Yes ◯ No ◯ Unknown
Cough	◯ Yes ◯ No ◯ Unknown
Diarrhea	◯ Yes ◯ No ◯ Unknown
Excessive sweating	◯ Yes ◯ No ◯ Unknown
Stool changes	◯ Yes ◯ No ◯ Unknown
Lethargy or sleeping more than usual	◯ Yes ◯ No ◯ Unknown
Difficulty breathing	◯ Yes ◯ No ◯ Unknown
Fussiness or excessive crying	◯ Yes ◯ No ◯ Unknown
Exposure to anyone who was sick *(e.g., at home or at daycare)*	◯ Yes ◯ No ◯ Unknown
Decrease in appetite	◯ Yes ◯ No ◯ Unknown
Falls or injuries	◯ Yes ◯ No ◯ Unknown
Other, specify: _____	◯ Yes ◯ No ◯ Unknown

Symptom	Within 72 hrs of incident	At any time
Allergies or allergic reactions *(food, medication, or other)*	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Abnormal growth, weight gain, or weight loss	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Apnea *(stopped breathing)*	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Cyanosis *(turned blue or gray)*	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Seizures or convulsions	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Cardiac *(heart)* abnormalities	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Colic *(frequent prolonged crying/chronic inconsolable fussiness)*	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Feeding issues *(e.g., reflux)*	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Vomiting	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Choking	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Other, specify: _____	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown

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 before death, was the infant given any vaccinations or medications? *(include any home remedies, herbal medications, prescription medications, over-the-counter medications)*

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

14. Was the infant last placed to sleep with a bottle? ◯ Yes ◯ No ◯ Unknown

If yes, was the bottle propped? *(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 familial relationship to infant)*

_____

16. Did the death occur during feeding? ◯ Breastfeeding ◯ Bottle-feeding ◯ Eating solids ◯ Not during feeding

17. Was the infant ever breastfed? ◯ Yes ◯ No ◯ Unknown *If yes*, for how many months? _____

18. What did the infant consume in the 24 hours prior to death?

Consumed?	If yes, describe	If yes, newly introduced?	If yes, was this the last thing consumed prior to incident?	If last fed, indicate quantity	If last fed, indicate date and time?
☐ Breastmilk		◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No		
☐ Formula		◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No		
☐ Water		◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No		
☐ Other liquids		◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No		
☐ Solids		◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No		
☐ Other		◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No		

19. Among the infant's blood relatives *(siblings, parents, grandparents, aunts, 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 the 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

1. Incident scene *(place infant found unresponsive or dead).* Type of location? *(e.g., primary residence, daycare, or grandmother'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 younger than 18 years of age were under the care of the provider at the time of the incident? *(including their own children)* _____

How many adults aged 18 years or older were supervising the child(ren)? _____

How long has the daycare been open for business? _____

Is the daycare licensed? ◯ Yes ◯ No ◯ Unknown

If yes: **License number?** _____ **Licensing agency?** _____

4. How many people live at the incident scene? **Children** *(younger than 18 years)* _____ **Adults** *(18 years or older)* _____

5. What kind of heating or cooling sources were being used at the incident scene? *(e.g., A/C window unit, wood-burning fireplace, or open window)*

6. Was there a working carbon monoxide (CO) alarm at the incident scene? ◯ Yes ◯ No ◯ Unknown

7. Indicate the temperature of the room where the infant was found unresponsive, and the surrounding area. *(fill in temperatures)*

Thermostat setting: _____ Thermostat reading: _____ Incident room: _____ Outside: _____ Time of reading: _____

8. Which of these devices were operating in the room where the infant was found unresponsive? *(check all that apply)*

☐ Fan ☐ Apnea monitor ☐ Humidifier ☐ Vaporizer ☐ Air purifier ☐ None ☐ Unknown

☐ Other, specify: _____

9. What was the source of drinking water at the incident scene? *(check all that apply)*

☐ Public or municipal water ☐ Bottled water ☐ Well water ☐ Unknown

☐ Other, specify: _____

10. Which of the following were present at the incident scene? *(check all that apply)*

☐ Insects ☐ Mold growth ☐ Smokey smell ☐ Pets ☐ Dampness ☐ Peeling paint ☐ Visible standing water
☐ Presence of alcohol containers ☐ Rodents or vermin ☐ None

☐ Odors or fumes, describe: _____

☐ Presence of prescription drugs, describe: _____

☐ Presence of illicit drugs or drug paraphernalia, describe: _____

☐ Other, describe: _____

11. Describe the general appearance of incident scene. *(e.g., cleanliness, hazards, or overcrowding)*

12. Is there anything else that may have affected the infant that has not yet been documented? *(e.g., drug or alcohol use at scene, history of domestic violence, or child abuse or neglect)*

INCIDENT CIRCUMSTANCES

1. Who was the usual caregiver(s)? *(name(s) and familial relationship to infant)* _____

2. Who was the caregiver(s) at the time of the incident? *(name(s) and familial relationship to infant)*

_____

3. Who found the infant unresponsive? *(If caregiver is same as birth mother Skip question #3)*

Full name: _____

Address: _____ City: _____

State: _____ Zip: _____ Date of birth: _____

Email address: _____ Phone number: _____

Work address: _____

Familial relationship to infant? *(e.g., birth mother, grandfather, or adoptive or foster parent)*

_____

4. Describe what happened. *(include details about how the infant was found)*

5. Was there anything different about the infant in the last 24 hours? ◯ Yes ◯ No ◯ Unknown

If yes, describe:

6. What was the temperature in the incident room? ◯ Hot ◯ Cold ◯ Normal ◯ Other

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 (P)laced before death, (L)ast known alive, (F)ound, and (U)sually placed? *(write P, L, F, or U, leave blank if none)*

_____ 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 _____ In-bed sleeper

_____ Other, specify: _____

_____ Adult bed — *If yes*, what type? ◯ Twin ◯ Full ◯ Queen ◯ King ◯ Unknown

◯ Other, specify: _____

9. Describe the condition and firmness of the surface where the infant was found.

_____

10. 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)* _____

11. What was the infant wearing? *(e.g., t-shirt or disposable diaper)* _____

12. What was the infant's usual sleep position? ◯ Sitting ◯ Back ◯ Stomach ◯ Side ◯ Unknown

13. Describe the circumstances of infant when last placed by caregiver, last known alive, and found.

	Placed	Last known alive	Found
Date			
Time			
Location *(e.g., living room or bedroom)*			
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)*			

14. 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

15. Indicate the items present in the sleep environment and their positional relation to the infant when the infant was found.

Item	Present?	If yes, position in relation to infant?	If yes, did object obstruct the infant's mouth, nose, chest, or neck?
Adult(s) *(18 years or older)*	◯Yes ◯No ◯Unknown	◯Over ◯Under ◯Next to ◯Unknown	◯Yes ◯No ◯Unknown
Other child(ren) *(younger than 18 years)*	◯Yes ◯No ◯Unknown	◯Over ◯Under ◯Next to ◯Unknown	◯Yes ◯No ◯Unknown
Animal(s)	◯Yes ◯No ◯Unknown	◯Over ◯Under ◯Next to ◯Unknown	◯Yes ◯No ◯Unknown
Mattress	◯Yes ◯No ◯Unknown	◯Over ◯Under ◯Next to ◯Unknown	◯Yes ◯No ◯Unknown
Comforter, quilt or other	◯Yes ◯No ◯Unknown	◯Over ◯Under ◯Next to ◯Unknown	◯Yes ◯No ◯Unknown
Fitted sheet	◯Yes ◯No ◯Unknown	◯Over ◯Under ◯Next to ◯Unknown	◯Yes ◯No ◯Unknown
Thin blanket	◯Yes ◯No ◯Unknown	◯Over ◯Under ◯Next to ◯Unknown	◯Yes ◯No ◯Unknown
Pillow(s)	◯Yes ◯No ◯Unknown	◯Over ◯Under ◯Next to ◯Unknown	◯Yes ◯No ◯Unknown
Cushion	◯Yes ◯No ◯Unknown	◯Over ◯Under ◯Next to ◯Unknown	◯Yes ◯No ◯Unknown
Nursing or u-shaped pillow	◯Yes ◯No ◯Unknown	◯Over ◯Under ◯Next to ◯Unknown	◯Yes ◯No ◯Unknown
Sleep positioner *(wedge)*	◯Yes ◯No ◯Unknown	◯Over ◯Under ◯Next to ◯Unknown	◯Yes ◯No ◯Unknown
Bumper pads	◯Yes ◯No ◯Unknown	◯Over ◯Under ◯Next to ◯Unknown	◯Yes ◯No ◯Unknown
Clothing *(not on a person)*	◯Yes ◯No ◯Unknown	◯Over ◯Under ◯Next to ◯Unknown	◯Yes ◯No ◯Unknown
Crib railing or side	◯Yes ◯No ◯Unknown	◯Over ◯Under ◯Next to ◯Unknown	◯Yes ◯No ◯Unknown
Wall	◯Yes ◯No ◯Unknown	◯Over ◯Under ◯Next to ◯Unknown	◯Yes ◯No ◯Unknown
Toy(s)	◯Yes ◯No ◯Unknown	◯Over ◯Under ◯Next to ◯Unknown	◯Yes ◯No ◯Unknown
Other, specify: _____	◯Yes ◯No ◯Unknown	◯Over ◯Under ◯Next to ◯Unknown	◯Yes ◯No ◯Unknown

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?	Fell asleep feeding infant?
					◯Yes ◯No ◯Unknown	◯Yes ◯No ◯Unknown
					◯Yes ◯No ◯Unknown	◯Yes ◯No ◯Unknown
					◯Yes ◯No ◯Unknown	◯Yes ◯No ◯Unknown

If yes to impaired, describe: _____

16. Were there any secretions present at the scene? ◯Yes ◯No ◯Unknown

If yes, describe: *(include where they were found)*

_____

17. Was there evidence of wedging? *(wedging is an 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 is an 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)*

Appearance	Present?	Describe and specify location
Discoloration around face, nose, or mouth	◯Yes ◯No ◯Unknown	
Secretions or fluids *(e.g., foam, froth, or urine)*	◯Yes ◯No ◯Unknown	
Skin discoloration *(e.g., livor mortis, pale areas, darkness, or color changes)*	◯Yes ◯No ◯Unknown	
Pressure marks *(e.g., pale areas, or blanching)*	◯Yes ◯No ◯Unknown	
Rash or petechiae *(e.g., small, red blood spots on skin, membrane, or eyes)*	◯Yes ◯No ◯Unknown	
Marks on body *(e.g., scratches or bruises)*	◯Yes ◯No ◯Unknown	
Other: _____	◯Yes ◯No ◯Unknown	

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, or parent)* _____

Date: *(mm/dd/yyyy)* _____ Time: _____

Type of compression? *(check all that apply)*

☐ Two finger ☐ One hand ☐ Two hands

Was rescue breathing done? ◯Yes ◯No ◯Unknown

The following questions refer to the caregiver(s) at the time of death.

24. Has the caregiver ever had a child under their care die suddenly and unexpectedly? ◯Yes ◯No ◯Unknown

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

_____

25. Were the infant and caregiver in the *same room* at the time of the incident, but not sharing the same sleep surface?

◯Yes ◯No ◯Unknown ◯N/A - sharing a sleep surface

26. Was the infant's caregiver using any of the following during the incident? *(indicate all that apply)*

Substance	Caregiver used?	Frequency
Over the counter medications	◯Yes ◯No ◯Unknown	
Prescription medications	◯Yes ◯No ◯Unknown	
Opioids	◯Yes ◯No ◯Unknown	
Tobacco, specify: *(e.g., cigarettes or e-cigarettes)* _____	◯Yes ◯No ◯Unknown	
Alcohol	◯Yes ◯No ◯Unknown	
Herbal remedies	◯Yes ◯No ◯Unknown	
Other, specify: _____	◯Yes ◯No ◯Unknown	

Was the infant's caregiver asked to consent to blood or urine for drug/alcohol testing? ◯Yes ◯No ◯Unknown

If yes, what were the results? _____

INVESTIGATION SUMMARY

1. Arrival dates and times.

Person(s) involved	Hospital	Incident scene
Infant		N/A
Law enforcement		
Death investigator		

2. Agencies conducting an investigation? *(check all that apply)* ☐ Child protective services
☐ Death investigator from medical examiner or coroner office ☐ Law enforcement, specify: _____
☐ Other, specify: _____

3. Indicate when the form was completed. Date: *(mm/dd/yyyy)* _____ Time: _____

4. If more than one person was interviewed, does the information provided differ? ◯ Yes ◯ No ◯ N/A
If yes, detail any differences or inconsistencies of relevant information. *(e.g., placed on sofa or last known alive on chair)*

_____

5. Indicate the task(s) performed. *(check all that apply)* ☐ Additional scene(s) *(forms attached)* conducted ☐ Photos or video taken
☐ Materials collected or evidence logged ☐ Next of kin notified ☐ 911 tape obtained ☐ EMS run sheet or report obtained
☐ Witness(es)/caregiver(s) interviewed

6. Was the family offered grief counseling services? ◯ Yes ◯ No ◯ Unknown

7. Was a doll scene reenactment performed? ◯ Yes ◯ No ◯ Unknown

If no, why? _____

If yes: How was it documented? *(check all that apply)* ☐ Photographed ☐ Videoed ☐ Other, specify: _____

Where was it performed? ◯ Incident scene ◯ Hospital ◯ Other, specify: _____

Indicate when the doll reenactment was performed. Date performed: *(mm/dd/yyyy)* _____ Time performed: _____

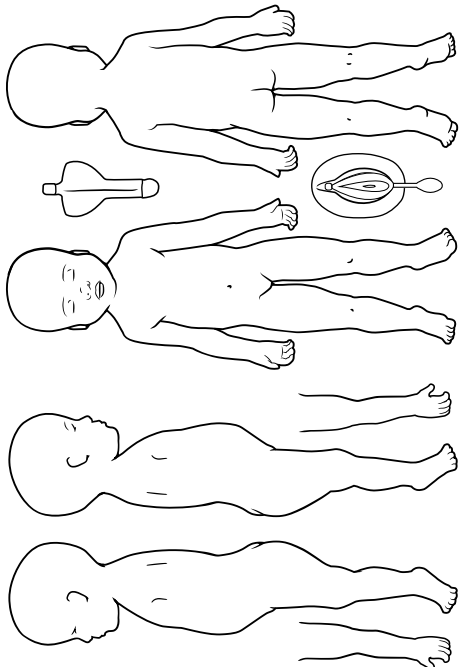
Were photos provided to the pathologist? ◯ Yes ◯ No ◯ Unknown

Do the scenarios given during the doll reenactment(s) match what was seen during the preliminary investigation?
◯ Yes ◯ No ◯ N/A

INVESTIGATION DIAGRAMS

1. Scene diagram *(illustrate the infant's sleep environment)*

2. Body diagram *(note visible injuries, livor mortis, or rigor mortis)*



3. Scene and doll reenactment photos *(include with form)*

SUMMARY FOR PATHOLOGIST

1. **Investigator information.** Name: _____ Agency: _____

   Phone: _____ Email address: _____

2. Indicate when the investigation took place. Date: *mm/dd/yyyy)* _____ Time: _____

3. Indicate when the infant was pronounced dead. Date: *(mm/dd/yyyy)* _____ Time: _____

4. Indicate when it is estimated the infant died. Date: *(mm/dd/yyyy)* _____ Time: _____

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 ☐ Photos/videos from caregivers demonstrating injuries, developmental milestone, or medical concerns ☐ Other, specify: _____

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

Sleeping Environment	Yes	No
Asphyxia *(e.g., evidence of overlying, wedging, choking, nose or mouth obstruction, re-breathing, neck or chest compression, or immersion in water)*	◯	◯
Sharing of sleep surface with adults, children, or pets	◯	◯
Change in sleep condition *(e.g., unaccustomed stomach sleep position, location, or sleep surface)*	◯	◯
Hyperthermia or hypothermia *(e.g., excessive wrapping, blankets, clothing, or hot or cold environments)*	◯	◯
Environmental hazards *(e.g., carbon monoxide, noxious gases, chemicals, drugs, or devices)*	◯	◯
Unsafe sleep condition *(e.g., non-supine, couch, adult bed, stuffed toys, pillows, or soft bedding)*	◯	◯

Infant History	Yes	No
Diet *(e.g., solids introduced)*	◯	◯
Recent hospitalization	◯	◯
Previous medical diagnosis	◯	◯
History of acute life threatening events *(e.g., apnea, seizures, or difficulty breathing)*	◯	◯
History of medical care without diagnosis	◯	◯
Recent fall or other injury	◯	◯
History of religious, cultural or alternative remedies	◯	◯
Cause of death due to natural causes other than SIDS *(e.g., birth defects or complications of preterm birth)*	◯	◯

Family Information	Yes	No
Prior sibling deaths	◯	◯
Sudden or 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 (*e.g., siblings, parents, grandparents, aunts, uncles, or first cousins*)	◯	◯
Previous encounters with police or social service agencies	◯	◯
Request for tissue or organ donation	◯	◯
Objection to autopsy	◯	◯

Exam	Yes	No
Preterminal resuscitative treatment	◯	◯
Signs of trauma or injury, poisoning, or intoxication	◯	◯

Other	Yes	No
Suspicious circumstances	◯	◯
Other alerts for pathologist's attention	◯	◯

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: _____

Visit https://www.cdc.gov/sids/SUIDRF.htm for Additional Investigative Scene Forms of Body Diagram, EMS Interview, Hospital Interview, Immunization Record, Infant Exposure History, Informant Contact, Law Enforcement Interview, Materials Collection Log, Non Professional Responder Interview, Parental Information, Primary Residence Investigation, and Scene Diagram.